ARIZONA STATE PLANNING GRANT

Final Report to the Secretary
U.S. Department of Health and Human Services

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Prepared by Arizona Health Care
Cost Containment System Administration

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EXECUTIVE SUMMARY

While historically Arizona has had one of the higher uninsurance rates in the nation, recently released U.S. Census Bureau data indicates that Arizona has made progress in improving health coverage in Arizona. Continual progress has been made in closing this gap in coverage with the recent Title XIX coverage expansions as part of the Arizona Health Care Cost Containment System (AHCCCS). Additionally, HB 2050 which was passed during the 2000 legislative session created a nine member Task Force charged with the development of an affordable health care insurance plan for all Arizonans by December 2001. Unlike many states which have focused principally on the uninsured, the State has taken a broader approach by focusing both on those individuals who currently are uninsured as well as those who have coverage but are continually being confronted with issues of accessibility, comprehensiveness and affordability which may ultimately lead to a lack of coverage.

The receipt of the one year $1.16 million dollar State Planning Grant from the Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS) in March 2001 lent tremendous support to the State's ongoing effort to develop a plan for providing Arizonans with affordable, accessible health insurance. This final report provides an overview of the activities conducted under the State Planning Grant, including information on health care coverage in Arizona, coverage options examined and findings and recommendations. The report has been organized according to the State Planning Grant Final Report format consisting of the following eight (8) sections:

- Executive Summary
- Uninsured Individuals and Families
- Employer-Based Coverage
- Health Care Marketplace
- Options for Expanding Coverage
- Consensus Building Strategies
- Lessons Learned and Recommendations to States
- Recommendations to the Federal Government

In this section, the Executive Summary, a brief overview is provided of the goals for the project and approach taken as well as the accomplishments and recommendations that resulted from the efforts under this grant.

State Planning Grant Project Goals

The project was planned and overseen by the AHCCCS Administration (AHCCCSA), the State's Medicaid agency. Under AHCCCSA's leadership the goals for the Arizona State Planning Grant were defined as follows:

- Through a nine-member Statewide Health Care Insurance Plan Task Force conduct public hearings, consider staff research results and recommendations, establish guiding principles, assess the feasibility of various strategies to address accessibility/affordability of health care and submit a final report with recommended action steps to the Legislature and Governor by 12/15/01 (See Attachment A).
- Form a Technical Advisory Committee in collaboration with the Task Force to provide guidance in the design and selection of options to enhance health coverage in Arizona.
- Review and compile information on current health care coverage in Arizona resulting in a report which sets forth information on population characteristics and employer composition, available health care coverage, characteristics of the uninsured population, health insurance costs and strategies to overcome barriers to coverage.
- Review current approaches/best practices being used by other states and their experience in adopting such approaches.
- Analyze and test proposed strategies; including soliciting input via community meetings/focus groups.
- In addition to the Task Force report, prepare and submit to HRSA a final report on the results of the State Planning Grant activities and state recommendations by 3/31/02.

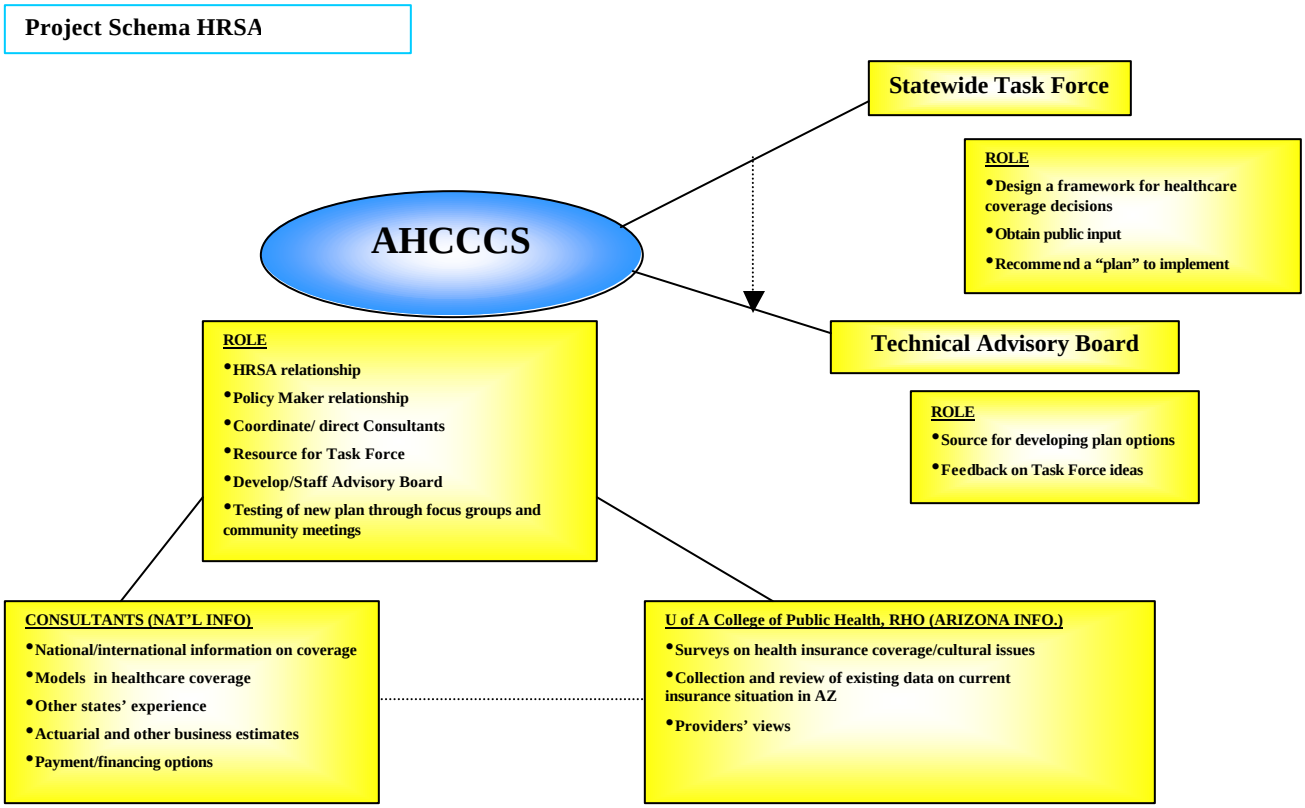
Project Approach

Organization

Upon receipt of the grant, AHCCCSA immediately put in place an organizational structure which involved:

- Provision of technical and staffing support to the Arizona Statewide Health Care Insurance Plan Task Force.
- Establishment of a Technical Advisory Committee of health care experts who are providing guidance in the development of options as well as feedback on proposed approaches.
- Engagement of the University of Arizona, College of Public Health, Rural Health Office, Southwest Border Rural Health Research Center (referred to as RHO through out this report) to compile information on health care coverage in Arizona.
- Contracts with various national consulting firms to provide technical support such as development of policy briefs on national/international strategies to address health care coverage issues, actuarial and financial analyses.

A more detailed explanation of individual roles and responsibilities can be found in the Project Schema for the State Planning Grant (see next page).



Data Collection

In order to understand health care coverage in Arizona and in particular who the uninsured individuals are, AHCCCSA did not undertake a primary data collection effort but instead relied on the analysis of secondary quantitative national and state-specific data using sources such as the Current Population Survey, the Medical Expenditure Panel Survey, state surveys, and state agency data reports. Additionally, extensive qualitative information regarding coverage issues and current approaches and best practices was obtained through literature reviews and discussions with staff from other state programs and other health care experts. The RHO, William M. Mercer, Inc., and Milliman USA, Inc., as well as AHCCCSA were instrumental in the compilation of this information.

Activities and Accomplishments

Background Information

To assist the Statewide Health Care Insurance Plan Task Force members in the identification of the most appropriate strategies for addressing the issue of affordable and accessible health care coverage, a key focus of the project was the education of the policy makers through the synthesis

of information, collection of data, preparation of briefing papers and formal presentations. This effort included both a national as well as a local focus.

National Perspective

Nine nationally focused policy issue papers were developed which included, where appropriate, a summary of current approaches/best practices being used by other states and their experience, an evaluation of the pros and cons of the approach(es) in the context of the guiding principles developed by the Task Force and the identification of issues that need to be considered in adopting various approach(es). These papers are available on the AHCCCS-HRSA State Planning Grant web site www.ahcccs.state.az.us/Studies/default.asp?ID=HRSA. These papers were completed by Milliman USA, Inc. (first four papers listed below) and by William M. Mercer, Inc. (last five papers listed below) and include:

- *Purchasing Pools* focuses on purchasing pools established for small-employee groups and individuals/families and their effectiveness in improving access and affordability to health insurance.
- *High-Risk Pools* examines the types of risk pools implemented by other states to cover residents whose medical costs preclude them from obtaining coverage at affordable prices in the private market.
- *Implementation of Incentives and Regulatory Mandates to Increase Health Insurance Coverage* provides an overview of incentives that have been implemented by other states to increase private health insurance coverage as well as provides commentary on the effectiveness of legislative mandates at the state level. Strategies examined include: those targeted at the consumer (e.g., tax credits, premium sharing, discount cards), health plan/insurance company (e.g., premium tax, mandated rural coverage, premium regulation, limits on waiting periods) and employers (e.g., tax credits, mandated payroll deductions for those employees participating in health insurance program).
- *International Approaches to a Socialized Insurance System* provides a brief overview of the socialized medicine approach to the delivery of health care that has been operating in European and other select countries.
- *Faces of the Uninsured and State Strategies to Meet Their Needs* identifies and describes the key sub-populations in Arizona that one needs to consider in addressing the issue of accessible and affordable health care coverage (e.g., low-income uninsured, working uninsured, rural uninsured) as well as a discussion of strategies used by states to address the needs of the specific sub-populations.
- *Initiatives to Improve Access to Rural Health Care Services* provides an overview of strategies that have been implemented by other states to increase access to health care in rural areas both in terms of increasing coverage and enhancing provider networks.
- *Health Insurance Administrative Costs* provides a brief discussion of the factors which impact administrative expenditures and provides percentages of total expenditures spent on administration by insurance plan types in 2000.

- *Elasticity of the Demand for Health Care Services* discusses the relationship between the demands for health care as it relates to the cost of care, arguing that health insurance is relatively inelastic.
- *Review of Self-Insuring of Health Benefits* explains the features and differences between fully insured funding arrangements and self-insured funding, as well as minimum premium funding which is a combination of fully and self-insured.

Arizona Perspective

In addition to looking at strategies implemented in other states, a number of the briefing papers focused specifically on Arizona. These papers included the following (first three completed by William M Mercer, Inc., and last one by AHCCCSA):

- *Arizona Basic Health Benefit Plan: A Comprehensive Review* examines the Arizona Basic Health Benefit Plan in the context of other states' approaches and critiques the plan in terms of benefit design variables as well as its overall affordability.
- *Financial Impact of Recently Enacted Health Insurance Mandates* examines the cost impact of recently enacted health insurance mandates in Arizona, e.g., direct access to chiropractic services, standing referral requirement and access to medical supplies.
- *HealthCare Group – Moving Towards Accountability: A Proposed Plan* recommends specific design changes for HealthCare Group from the viewpoint of the uninsured and to ensure continual health plan participation.
- *Inventory of Arizona Strategies to Address Rural Health Care Infrastructure* provides an inventory of the strategies that have been implemented in Arizona to address rural health care infrastructure issues.

The RHO produced two documents - *Health Care Coverage in Arizona: An Overview* as well as *Health Care Coverage in Arizona: Data Book* in which information was analyzed and compiled on:

- Population characteristics and employer composition at both the State and county level.
- Available health care coverage options in Arizona.
- Characteristics of Arizona's uninsured population.

Committee Support

Statewide Health Care Insurance Plan Task Force

Over the past year, the Task Force held eight meetings for which AHCCCSA played a lead role in the provision of technical assistance and staffing support. These meetings served multiple functions, allowing Task Force members to hear formal presentations by experts in the community, to receive public testimony and to discuss key issues and solutions related to the provision of accessible and affordable health care coverage in Arizona. Two key outcomes from these meetings were:

- The development of an agreed upon set of basic principles for health care coverage in Arizona which are intended to serve as the framework for guiding the Task Force in the formulation of final recommendations.
- Final recommendations which supported proposed changes to HealthCare Group and introduction of legislation to establish a more defined framework within which the State can continue its efforts to develop a seamless health care system in Arizona.

A summary of the Task Force activities and recommendations can be found in the *Final Report Statewide Health Care Insurance Plan Task Force* (See Attachment A).

Technical Advisory Committee

The Technical Advisory Committee (TAC) established by AHCCCSA served in an advisory capacity to both AHCCCSA and the Statewide Health Care Insurance Plan Task Force; providing guidance in the development of plan options as well as feedback on proposed approaches. The TAC was composed of representatives from the physician community, insurance companies (urban/rural, commercial and specialty), hospitals (rural and urban) and state agency directors of AHCCCSA and Department of Insurance. The TAC primarily focused on the development of strategies which "use available, affordable, financial insurance vehicles to reduce the uninsured population that would not be eligible for public programs." Strategies they recommended to the Task Force included:

- Community-based education on the value of insurance.
- High-risk pool using multiple funding sources (e.g., public, private and insurance premium funded).
- Ability to market flexible benefit packages that could be adapted to current marketplace demands.

(See AHCCCS-HRSA project Web site for additional information about the TAC including the meeting minutes).

Recommendations and Findings

Overall, AHCCCSA found that the State Planning Grant project provided a solid base for moving forward the debate of how best to provide accessible and affordable health care coverage to all Arizonans. Due to the current budget crisis in the State of over a $1.2 billion shortfall for FY2003, consideration of additional expansion options which required state funds was not feasible at this time. Additionally, the State had recently undertaken a major Title XIX coverage expansion through the implementation of Proposition 204. Given these factors the focus was placed on (1) trying to maintain those programs that have proven to play an effective role in making health care coverage accessible and affordable and (2) to continue the development of a framework for the implementation of strategies addressing the issue of accessible and affordable health care in Arizona.

Key to this effort was the recommendations set forth by the Statewide Health Care Insurance Plan Task Force in December which included the following:

- Introduction of legislation which would continue the efforts of the Task Force by continuing to develop strategies which would:

  - Narrow the gap between existing public and private health coverage programs (e.g., through implementation of insurance reform, consumer and employer education initiatives, private-public coverage programs, program for cooperative purchase of employee healthcare benefits by small group employers).
  - Restructure current state employee and retiree health care coverage programs (e.g., self-insurance system and expansion of pool size).
  - Enhance existing public supported programs (e.g., effective outreach programs, expansion of coverage groups).
  - Improve the rural health care infrastructure through a variety of strategies including development of a plan to more effectively coordinate current rural health care resources and programs.

- Continue support for HealthCare Group through adoption of proposed changes - only subsidizing low-income, streamline benefit options, and revise underwriting methodology so premium structure is figured using an incremental scale based on employee age and household. (Note: HealthCare Group targets the small-employer group marketplace between 1 and 50 employees and political subdivisions regardless of size.)

In addition to these Task Force recommendations, AHCCCSA learned a number of operational lessons during the course of the grant which new State Planning grantees should consider when designing their projects. AHCCCSA found the project organizational structure to be very effective for supporting the grant's purpose by allowing for active legislative involvement but at the same time allowing for valuable input from key stakeholders. Due to the complex nature of the subject matter, education of the Task Force members as well as the public proved to be a critical component for developing the framework for future decisions regarding coverage strategies. Lastly, to support this effort AHCCCSA was able to effectively draw from data and information available nationally and locally, avoiding a state specific data collection effort which can be both costly and time consuming. However, it is recognized that as the State narrows down its options and develops specific proposals, state specific data will become more critical for evaluating these options.

It is important for the Federal Government to recognize that states' abilities to expand coverage and develop a seamless system of care which is accessible and affordable is hampered by the Federal Government's role as both a regulator of self-insured plans and an administrator of major coverage programs, e.g., Medicare, Indian Health Service, and Veterans Affair. Additionally, if states are to be successful in their efforts to expand coverage the Federal Government needs to move away from enactment of body part legislation and work in close partnership with the states by allowing more flexibility in operation of programs such as Medicaid and State Children's

Health Insurance Program (SCHIP) and providing financial support for program expansions as well as support for states' research efforts to develop strategies to provide accessible and affordable health care. It is only through this type of federal-state partnership that the issue of health care coverage in Arizona and the nation as a whole can be effectively addressed.

Future Activities

With the extension of the State Planning Grant for another year, AHCCCSA will continue to analyze and develop specific policy options that address the recommendations set forth in the Task Force legislation; allowing the state to move forward with some specific/targeted strategies that will improve the affordability and accessibility of health care in Arizona. In particular three (3) specific State Planning Grant activities which AHCCCSA is currently working on include:

- Feasibility of Employer-Sponsored Insurance Program. In December, the Center for Medicare and Medicaid Services (CMS) approved Arizona's Health Insurance Flexibility and Accountability (HIFA) waiver to expand coverage beginning October 1, 2002 to parents of Medicaid and SCHIP children with family income between 100 to 200% of Federal Poverty Level (FPL). As part of this expansion, the AHCCCSA is exploring the feasibility of implementing an employer sponsored pilot program.

- Rural Provider Interviews. In order to clearly identify both the barriers that discourage providers from practicing in rural areas as well as effective strategies for further developing the rural provider network, AHCCCSA will conduct interviews with targeted groups of rural health care practitioners around the State.

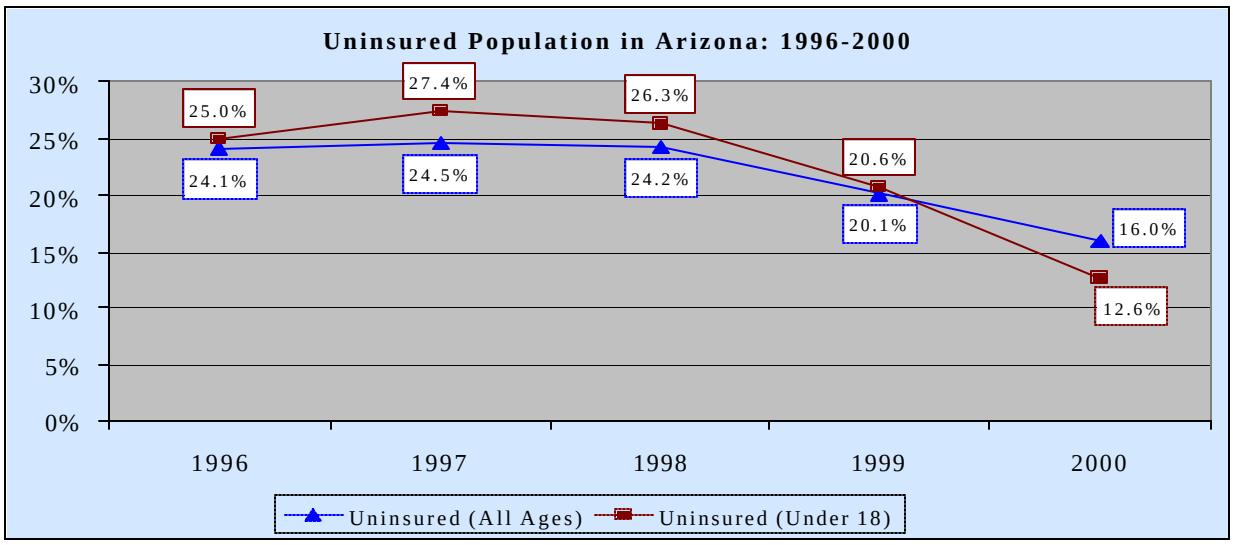
- Small-Group Package: In an effort to look at more affordable options for the small group market, sample rates are being developed for a model in which a small-group HMO plan utilizes the AHCCCS provider network.

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

This section provides an overview of who the uninsured are in Arizona including a discussion of coverage barriers and the role safety-net providers play in addressing their health care needs. Except where indicated, this information was primarily compiled through the efforts of the RHO and William M. Mercer, Inc. and was shared and discussed with both the Statewide Health Care Insurance Plan Task Force and Technical Advisory Committee. More detailed information can be found on the AHCCCS-HRSA State Planning Grant web site www.ahcccs.state.az.us/Studies/default.asp?ID=HRSA.

Description of the Uninsured in Arizona

Recent figures released by the U.S. Census Bureau reveal that the overall rate of uninsurance in Arizona for all ages has decreased substantially over the past three (3) years from 22.5% in 1998 to 20.0% in 1999 to 16.0% in 2000.[1] This has moved Arizona from having the second highest number of uninsured to having the ninth worst record. When looking at the rate of uninsured for the population under 18 years of age, the rate has decreased from 26.3% in 1998 to 12.6% in 2000 (moving Arizona from the highest number of uninsured children to having the 14th worst record). The RHO contributes most of this improvement to the increase in employer-sponsored health insurance driven by the State's strong economy and the variety of strategies employed by the State to increase both private and public health care coverage in recent years.



Some of the key characteristics defining Arizona's uninsured population are described below. This analysis is based primarily on the use of merged Current Population Survey (CPS) data from 1997 to 1999. It is important to recognize that this data does not adequately reflect the

impact of implementing KidsCare (i.e., Title XXI) or the recent Title XIX coverage expansion on 4/1/02 for adults with incomes up to 100% of FPL.

- Income: Those with income below 200% of FPL are more likely to be uninsured than higher income persons. Nearly three-quarters (74%) of the non-elderly uninsured (ages 0-64) reside in family units with incomes below 200% of FPL.

- Age: Overall, children have a lower rate of uninsurance. Those ages 18 to 24 are more likely to be uninsured than any other non-elderly age group.

- Gender: More adult males (especially young adult males) are likely to be uninsured than adult females (29% vs. 25%).[2]

- Family Composition: For the HIFA waiver proposal, AHCCCSA used merged CPS data from 1998 to 2000 and found that three-quarters of the uninsured low-income population (i.e., below 200% of FPL) represent children and parents (54% and 22%, respectively). For the remaining 24% who are adults without children, 57% are below 100% of FPL. It is important to note that many of these individuals will qualify for AHCCCS, i.e., the children under Title XIX/XXI and the adults whose income is below 100% of FPL under the recent coverage expansion and parents with Title XIX/XXI children whose income is below 200% of FPL under the approved HIFA expansion slated for implementation on 10/1/02.[3]

- Race/Ethnicity: As a border state to Mexico, Arizona tends to have a high concentration of uninsured Hispanics. At 45% Hispanics have a much higher uninsurance rate than any other ethnic group in the State (i.e., Non-Hispanic White at 19%, African-American at 23% and all others at 26%). While the Hispanic population comprises only one-quarter (25%) of the Arizona population, they represent more than half (52%) of the Arizona uninsured population. William M. Mercer, Inc. notes that there is a lack of detailed uninsurance data on the Hispanic uninsured in Arizona but looking at national data indicates that low-income is a key driver affecting the Hispanic uninsured with many working for smaller-employers who do not offer benefits.

- Immigration Status: Recent immigrants and their children who lack health coverage constitute only 5% of the uninsured. Looking at data for the US, it was noted that Hispanics who are non-citizens have an uninsurance rate of 58%, compared to a 29% uninsurance rate for Hispanics who are citizens.

- Geographic Location: National demographics for the US show that rural residents are more likely to be uninsured than their urban counterparts. Twenty-three percent of Arizona's population resides in semi-rural or rural areas. While all areas of the State have a large number of small-employers, the rural counties were found to have a high percentage of households with low-incomes and/or high unemployment, factors which are key drivers of uninsurance.

- Employment Status: The majority of the uninsured are "working uninsured". 75% of the uninsured are in a family unit with at least one full-time worker and 9% are in a family unit with at least one part-time worker. Although these family units have a linkage via an employee to the workplace, employer-based health care coverage is not necessarily offered. As discussed in the next section, 97% of Arizona employers consist of fewer than 100 employees who are also the least likely to offer insurance and the most likely to have higher than average insurance rates. This is borne out by the fact that uninsurance rates increase as firm size decreases (e.g., 45% uninsurance rate for firms of less than 10 employees to 19% for firms of 1,000 or more employees.)

Louis Harris and Associates who were commissioned by the Phoenix-based Flinn Foundation conducted a comprehensive survey on health care in Arizona in 1989 and again in 1995. While the information is seven (7) years-old, it reinforces many of the trends that were noted above, e.g., a predominant characteristic of the uninsured are low-income and are employed with a decline in the proportion of adults who were uninsured as the size of the employer increased. Additionally, the studies found that:

- Most uninsured had been uninsured for two years or longer.
- Most uninsured persons cited the cost of insurance as the reason they did not have it, with only 7% saying they "don't want it" and 3% saying they are unable to obtain insurance due to a pre-existing condition.
- In 1995, nearly 60% of the uninsured had not seen a doctor in the prior year with almost half saying that they had put off or postponed getting needed medical care for financial reasons.

More information on these studies can be found on the Flinn Foundation's Web site.[4]

Uninsured Sub-Populations

The William M. Mercer, Inc. policy issue paper, *Faces of the Uninsured and State Strategies to Meet Their Needs* clearly demonstrated that the uninsured population is not a single, homogeneous population but is comprised of a number of smaller sub-populations, formed by several key drivers of uninsurance which include age, employment (status and firm size), income (relative to poverty level), ethnicity and geography (urban vs. rural). Four (4) key uninsured sub-population groups in Arizona are identified that due to their size should merit a closer look by policy makers as they craft solutions to health coverage. The identified sub-populations which are not mutually exclusive included:

- Low-Income Uninsured, especially low-income uninsured children and their parents.
- Ethnic Uninsured, especially low-income Hispanics uninsured.
- Working Uninsured, especially working uninsured in small-employers.
- Rural Uninsured, especially rural low-income uninsured children and their parents.

In addition to the sub-populations identified above, the Statewide Health Care Insurance Plan Task Force initially identified the uninsured pre-retirement group as a sub-population that they

were concerned about due to constituent inquiries. However, this group became less of a focus when William M. Mercer, Inc. presented information to the Task Force members showing that Arizonans ages 45 to 64:

- Represented 24% (1.0 million) of the non-elderly Arizona population (or 20.8% of the total Arizona population).
- Generally had higher incomes than the Arizona population as a whole.
- Had 205,000 who were uninsured.
- Represented 19% of the non-elderly uninsured population in Arizona.

The Technical Advisory Committee felt that it was important to focus on the sub-population of uninsured individuals who were not eligible for public funded programs. William M. Mercer, Inc. estimated that 50% of the current uninsured population could be covered through publicly funded programs if they applied.

Factors Contributing to the Lack of Health Care Coverage

Based on the analysis of Arizona's health care marketplace, some of the key factors contributing to the lack of health care coverage and individuals' ability to obtain health care coverage that were identified by the RHO and William M. Mercer, Inc. included:

- Lower-income workers, especially those who work part-time cannot afford health insurance premiums.
- Lack of adequate income to convert employment-base health policies to continue coverage for their families after involuntary layoffs.
- Smaller firms are less likely to offer insurance.
- Populations eligible for public programs do not know that they are eligible and do not know how to become eligible.
- Changes in immigration laws have made it more difficult for public advocates to find and enroll eligible population in AHCCCS, e.g., fear of deportation, cultural and language barriers.
- A belief that insurance is not necessary, e.g., the "Superman" effect resulting from the young healthy populations who sees themselves as indestructible and feel no need for health insurance coverage.

Additionally, for residents in rural areas of the State who have an increased risk of uninsurance compared to their urban counterparts, the ability to access and receive adequate health care is made more difficult due to three (3) fundamental barriers:

- A critical lack of physicians and other providers.
- Geographic isolation.
- Hospital solvency.

The impact of these "rural barriers" is reflected in the fact that, of Arizona's 14 counties, three (3) entire counties are federal Medically Underserved Areas (MUA), a measure that includes

both provider shortages and poorer health outcome. Additionally a substantial portion of ten (10) other counties are designated as a MUA.

Affordability

In *Arizona Basic Health Benefit Plan: A Comprehensive Review*, William M. Mercer, Inc., noted that if the premium levels of the Basic Plan are set equal to the average cost of insurance available on the small-group market, a price generally available to the uninsured population already, then the plan will likely not be effective in meeting the financial needs of the uninsured. More reasonable comprehensive benefit designs will not be affordable to low-income uninsured without the use of significant subsidies by employers, state agencies or other sources. As illustrated through case studies presented in the paper for someone at 200% of FPL, the typical premium and costs of deductibles and coinsurance can exceed 20% of the family's income.

The issue of affordability as it relates to the purchase of health insurance for low-income individuals/families is further supported by the recent release of *The Self-Sufficient Standard for Arizona* which looks at how much income is needed for a family to meet its basic needs (i.e., housing, child care, health care food, transportation and taxes) without public or private assistance. It details the basic living expenses for various family compositions (e.g., one adult, one preschooler) in all 15 Arizona counties. For a family of three in Tucson (one parent, one preschooler and one school age child), the family would have to earn approximately $34,159 to meet all their basic needs including health care. This annual salary represents 227% of the FPL.[5]

Safety-Net for the Uninsured

As in other states a significant level of health care and other related services are delivered to the uninsured through a core set of safety-net providers. In Maricopa County it was estimated that 38% of individuals served in 2000 by primary care safety-net providers were uninsured. The safety-net providers include public and privately supported hospital systems, community health centers or clinics, local health departments, individual practitioners and other health care entities. These providers are supported through federal, state, local and private dollars. Due to limited resources, the safety-net providers clearly do not meet all the health care needs of these populations. In particular specialty care, including dental and behavioral health care has been cited as the missing piece of the safety-net puzzle.[6]

Over the years, the State has continued to support the safety-net providers through the allocation of tobacco tax monies to a myriad of programs. Two (2) key programs that have been funded with these monies include:

- Primary Care Program in which 22 primary care agencies provide comprehensive primary care services to low-income at risk residents at 85 service delivery sites around the State. $5.5 million was appropriated to this program in FY2002.

- Community Health Centers in which 17 center operating 21 delivery sites provide primary health care services to low-income or uninsured Arizonans. $4.5 million was appropriated in FY2002.

Other examples of safety-net programs recently initiated in the State include:

- Pima Community Access Program, is helping to increase access to uninsured residents by providing heavily discounted primary care, specialty care and hospital services. Implemented in September 2001, the program has already attracted 869 enrollees. It is expected that by June 2002, a pool of funds will be established from which patients can borrow to pay for high cost services such as surgery.
- Arizona Latino Medical Association with the support of the St. Luke's Charitable Health Trust has implemented an initiative in which Hispanic families pay a small annual fee which then allows them to access a network of practitioners and pharmacists who are willing to discount the cost of their services/products by 25 to 50%.

Finally, recognition needs to be given to the proportion of medical care that is rendered as charity by established private providers and practitioners. Based on a survey conducted by Arizona Hospital and Healthcare Association of Arizona hospitals, it has been estimated that a total of $387 million in uncompensated care was provided in 2001 with $306 million in bad debt and $81 million in charity care. An examination of hospitals in Maricopa County shows that while some hospitals are more central to the core safety-net system (i.e., Maricopa Integrated Health Systems), all hospitals are safety-net providers.[6]

SECTION 2. EMPLOYER-BASED COVERAGE

This section focuses on employer-based coverage in Arizona and includes a discussion of the characteristics of Arizona's business environment and who offers to provider and who opts to enroll in such coverage. Except where indicated, this information was compiled by the RHO drawing on data from Agency for Health Care Research and Quality, Center for Cost and Financing Studies, 1996-1999 Medical Expenditure Panel Survey (MEPS) – Insurance Component, Arizona Department of Economic Security, Research Administration and US Census Bureau. This information was shared and discussed with both the Task Force and Technical Advisory Committee. More detailed information can be found on the AHCCCS-HRSA State Planning Grant web site www.ahcccs.state.az.us/Studies/default.asp?ID=HRSA.

Characteristics of Arizona Businesses and Employment

The structure of employment in Arizona is somewhat different from the rest of the United States. The largest employment sector in Arizona is the service-producing industry, which provides 82.4% of all employment (vs. 77.3% in the US). In the manufacturing sector, Arizona trails the US (9.7% vs. 15.4%).

The majority of Arizona employers (97%) represent small firms (fewer than 100 employees). The smallest firms, those with fewer than 10 employees, comprise 74.4% of all firms in Arizona, while large firms, those with 1,000+ employees, comprise 0.2% of all firms. However, the 87,131 smallest employers employ only 10.2% of all employees, whereas the 197 largest employers employ 23.0% of the labor force.

Although the unemployment rate in Arizona generally is lower than the national average, the median household income is only $38,537 (vs. US average of $49,497) with 15.6% of the population below 100 % of FPL (vs. 12.5% for the US). The Commonwealth Fund 9/8/00 report, *Uninsured and at Risk: Coverage Profiles and Trends among 10 States* noted that the proportion of Arizona employees who have low hourly wages (i.e., under $10/hour) is higher when compared to the national percentage. Additionally, unemployment rates in Arizona are typically higher in the non-urban counties; along with a higher percentage of the population below 100% of FPL.[7]

Employer-Based Coverage in Arizona

General Description

Over the past five years, the number of Arizonans with employer-sponsored insurance has increased from 50.3% in 1996 to 59.4% in 2000. The US population had a higher proportion of persons with employer-sponsored health care coverage (64.1%). The Commonwealth Fund's

9/8/00 report, *Uninsured and at Risk: Coverage Profiles and Trends among 10 States"* contributes Arizona's higher uninsured rates to its lower rates of employer-based health insurance coverage. Using merged CPS data for 1997-1999, the Kaiser Foundation's *State Health Facts Online – Arizona: At-A-Glance* which provides demographic data for Arizona's non-elderly population with employer coverage shows:[2]

- As reflected nationally, the rate of non-elderly individuals with employer coverage increases with income with 17% under 100% of FPL, 47% at 100 to 199% of FPL and 79% at 200% of FPL or more.
- More adults (61%) than children (54%) have employer coverage.
- Employer coverage does not differ by gender.
- The rate of employer coverage differs markedly by race/ethnicity – 38% for Hispanics, 56% for others, 62% for blacks and 69% for whites.
- Family units with at least 1 full time worker are more likely to have employer coverage (65%) than if there are no full time workers (31%) or non-workers (26%).

The percent of private-sector employers who offer health insurance decreases as the size of the firm decreases (see Table below). Approximately 80% of employees (full and part-time) who work for firms that offer health insurance are eligible for coverage and of those about 81% of them opt to enroll in the coverage. These percentages change substantially for part-time employees in which the percent of employees eligible for insurance coverage through their employee is 24.8% with 67.6% opting to enroll in coverage. Lastly, according to MEPS data in 1998, 29% (or 27,234) of the private sector establishments in Arizona that offered health insurance, self-insure at least one plan.

Arizona Private-Sector Employers Who Offered Health Insurance by Firm Size: 1996 - 1999

Year	Total	Less than 10 Employees	10 – 24 Employees	25 – 99 Employees	100 – 999 Employees	1,000 or More Employees
1996	55.1%	32.9%	72.6%	73.5%	78.9%	88.6%
1997	53.2%	31.3%	50.0%	87.7%	100%	99.2%
1998	53.7%	32.8%	59.6%	78.4%	96.3%	95.5%
1999	58.8%	35.7%	65.9%	83.9%	96.2%	99.4%

Source: Agency for Healthcare Research and Quality, Center for Cost and Financing Studies, 1996 – 1999 Medical Expenditure Panel Survey – Insurance Component.

From 1996 to 1999, the national average single premium dollar cost rose from $1,991 in 1996 to $2,324 in 1999. Arizona's overall premium dollar cost rose from $1,791 to $2,097 during this time period, but fell slightly between 1998 and 1999. Further in 1999, Arizona employees paid a lower percentage of wages and average dollar amount for the premium (17.4% and $365) than other US workers (18.1% and $420). During the period 1996-1999, both the national and Arizona average family premium cost rose, but Arizona employees continued to pay a lower average family premium than other US families in 1999 ($5,509.34 vs. $6,058.12).

Small Size Employer Surveys

During the past year a number of surveys have been conducted of small size employers in order to better understand their issues regarding purchasing of health insurance. In all the surveys affordability and accessibility of health insurance is raised as a key concern. Additionally, for some small-business the purchasing of health insurance for employees is not viewed as a key business priority. A brief overview of these surveys is provided below.

Small-Business Survey Arizona 2000

In 2000 a random telephone survey of 401 owners and managers of Arizona business having fewer than 50 employees was conducted by WestGroup Research for the Arizona Hospital and Healthcare Association, Arizona Chamber of Commerce, Blue Cross and Blue Shield of Arizona and the St. Luke's Charitable Health Trust.[8] The results found that for small-businesses in Arizona, employee health is not generally seen as a primary business issue with key areas of concern being maintaining a quality workforce, meeting customer needs or governmental regulation.

In terms of health care coverage participation:

- One-third of the businesses surveyed offered health care coverage.
- The more employees in the firm, the more likely the firm was to offer health care coverage.
- Firms in metro Arizona were more likely than those in rural areas to offer health care coverage.
- There was little difference by industry type in the percentage offering employee health care coverage.

Firms who offered health coverage recognized that it was important to employees and used it to attract and keep them. They would only discontinue coverage in the face of a major increase in the cost of premiums. Due to cost half of these firms offered employee-only coverage. The average company contribution for employee coverage is 75% with eight percent paying 40% or less. For family coverage the average company contribution is 50%. Of their employees who decline coverage (18.6%) it is generally because they have coverage through a spouse (41%) or they can not afford it (26%).

Firms that did not offer coverage did not see a strong link between offering a health care plan and attracting and keeping employees. It was seen as a major drain of finances; requiring a major commitment of resources. Many of these employers rejected the possibility without even investigating coverage options. These firms noted the following factors might increase the likelihood that they would offer employee health insurance:

- 25% tax credit in addition to the normal deduction (27%).
- Possibility of having a harder time getting and retaining employees (25%).

- Tax on firms that did not offer (21%).
- Competitors offered a plan (15%).
- Lower premiums (25%).

Department of Insurance

As part of a recent evaluation of Arizona's Accountable Health Plan (AHP) laws, the Arizona Department of Insurance conducted an informal survey of groups that represented the interests of small-business employers in order to find out the experiences of their members or clients in the small group health insurance market.[9] The survey responses indicated that:

- Small-employers still experience limited access to group health insurance for reasons of both availability and affordability.
- Ongoing impediments to availability were related to administrative factors, compliance issues, product limitations and lack of competition.
- Small-employers uniformly describe affordability as the biggest access issue and perceive employee health status, prescription drugs, statutory mandates and lack of competition to be the primary affordability problems.

National Federation of Independent Business in Arizona

The National Federation of Independent Business in Arizona (NFIB Arizona), which conducted a recent survey of Arizona small-business owners, found that the cost of health care was a top issue for small-businesses and are recommending to the State Legislature as part of their 2002 agenda:

- No new state health mandates.
- Increase buying power of small-businesses by allowing them to pool together.
- Provide a health insurance income-tax credit (state and/or federal) for working uninsured.
- Create state medical Savings Accounts, tax-free accounts to help pay for the cost of health care that can roll over balances to future years.

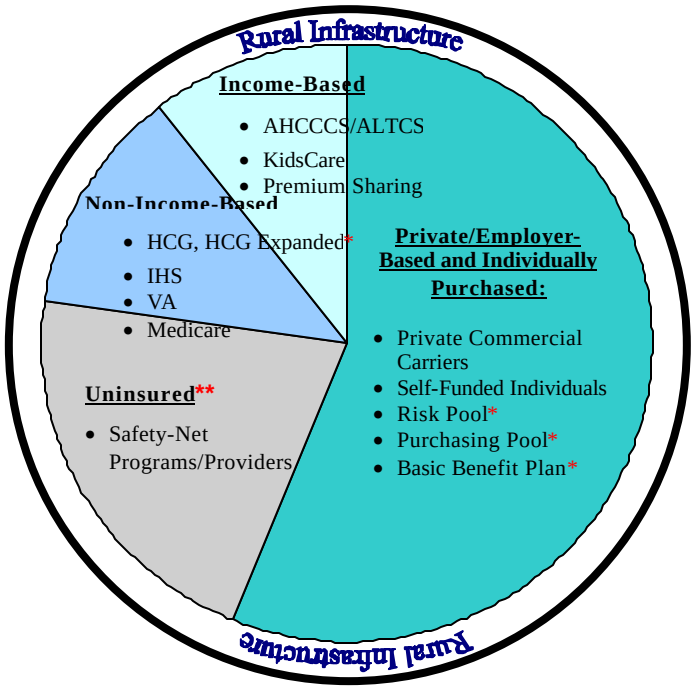
SECTION 3. HEALTH CARE MARKETPLACE

This section provides a description of the health care marketplace in Arizona as well as an overview of the findings from the numerous policy issue papers that were developed with the support of State Planning Grant (See the AHCCCS-HRSA State Planning Grant web site www.ahcccs.state.az.us/Studies/default.asp?ID=HRSA for specific papers). This information was compiled from literature reviews, discussions with state staff responsible for health coverage programs in selected states and staff consultants with work experience on various programs and analysis of local state data files. The resulting issue briefs, in turn were distributed to both the Statewide Health Care Insurance Plan Task Force and Technical Advisory Committee and discussed at subsequent meetings of the groups.

Description of Health Care Marketplace in Arizona

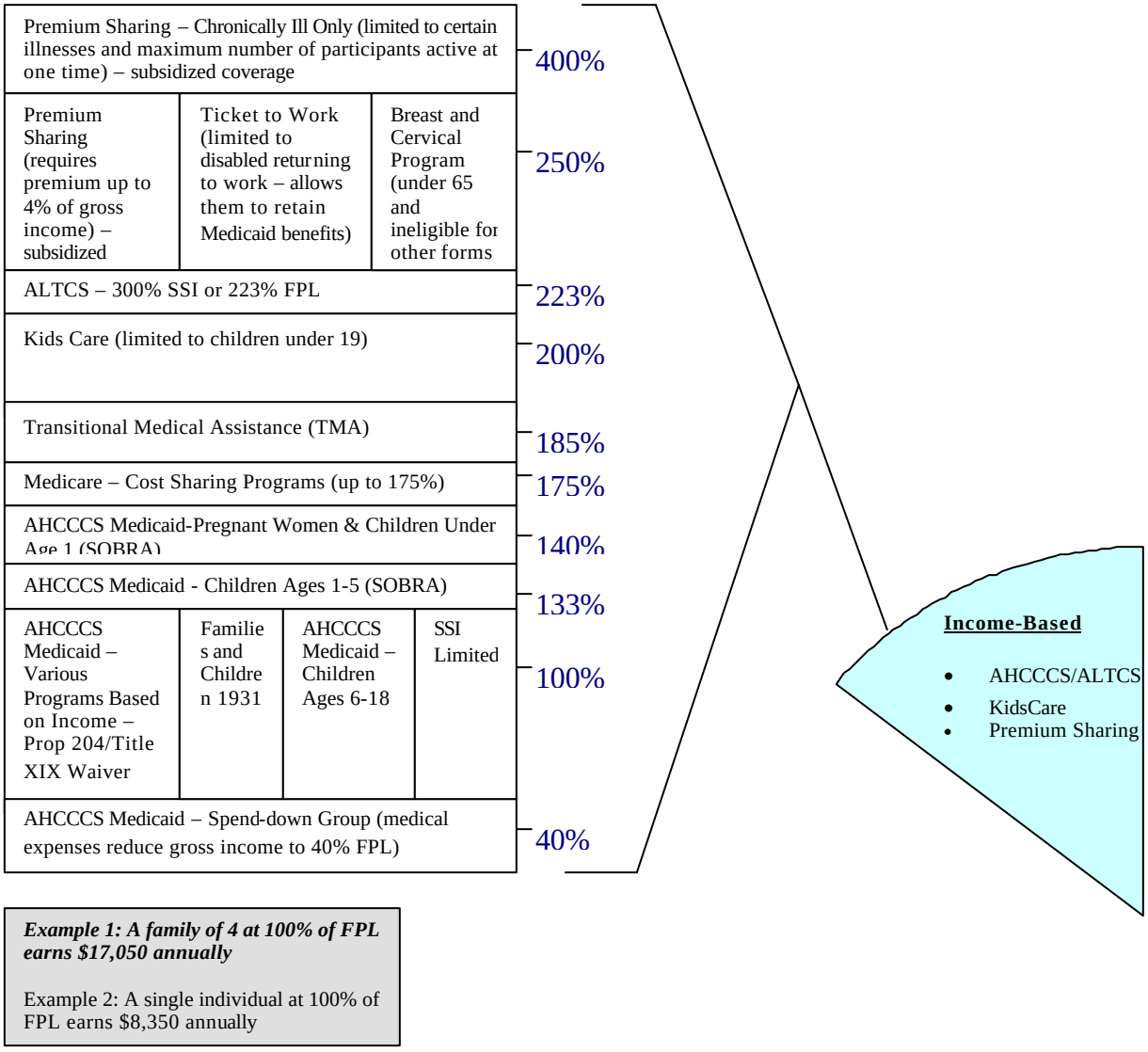
A general overview of health care coverage in Arizona is set forth in the following two diagrams – "Health Coverage in Arizona" and "Health Coverage in Arizona (Income-based)". These diagrams along with several others were prepared by AHCCCSA for the Task Force (See AHCCCS-HRSA Web site) in order to illustrate the types of coverage and the income criteria for those publicly sponsored programs that AHCCCSA administers.

Health Care Coverage in Arizona



* = Proposed Programs being considered by the Task Force
** = Uninsured Characteristics:
- Rural Areas
- Small & Medium Employers
- Low-Income (not poor)
- Early Retirees
- Eligible, but not enrolled

Health Coverage in Arizona: Income-Based



Example 1: A family of 4 at 100% of FPL earns $17,050 annually

Example 2: A single individual at 100% of FPL earns $8,350 annually

Although lower than the national average, the majority of Arizonans are still covered through employer-based coverage. It has been estimated that approximately 13% of Arizonans are covered through publicly funded income-based programs (i.e., Title XIX/XXI). As of 03/01/01, 748,689 Arizonans are enrolled in AHCCCS. In addition to the publicly supported programs, the State of Arizona also is the largest employer in the state currently employing 59,348 individuals. Out of these employees, approximately 54,000 are enrolled in the State's health plan through CIGNA HealthCare of Arizona.

The State has one of the most aggressive and competitive health care marketplaces in the US. Unlike many other states, the Arizona health care marketplace made the shift from indemnity insurance to managed care (i.e., with 31% in managed care in 1989 and 52% in 1995 – Flinn Foundation study). Today Arizona is in the top ten states in HMO penetration rates and has

87.5% of Arizonan residents receiving health care benefits through managed care insurers. This is further exemplified by the fact that almost all individuals who are enrolled in the AHCCCS programs (i.e., Title XIX/XXI) receive their health care through HMOs. This same phenomenon is also reflected in the Medicare managed care market, especially in the urban marketplace (i.e., 42% of Medicare beneficiaries in Phoenix were enrolled in Medicare+Choice plans).[10] In May, the Arizona Department of Insurance reported that there were 240,000 seniors enrolled in Medicare+Choice plans.

The RHO found that overall, Arizona has a low health care expenditure per capita (ranked 41st). In Arizona during 1998, $14.78 billion was spent on health care, or 11% of the gross state product. The three highest health care expenditure categories for Arizona in 1998 were physicians and other professional services ($5.14 billion or 34.7%), hospital services ($4.98 billion or 33.7%) and drugs and other medical non-durables at ($2.07 billion or 14%).

Over the past decade, Arizona has taken a number of steps to address the adequacy of health coverage in the State through health care market reform. This reform has involved both public as well as private sponsored reform; primarily targeting low-income, chronically ill and small-employer groups. Examples of this include:

- HealthCare Group, implemented in 1988, offers affordable and accessible health care coverage to small-businesses with 50 or fewer employees. Since 1999, HealthCare Group receives an annual state subsidy of up to $8 million.
- Small group market insurance reforms beginning in 1993 with the Accountable Health Plan laws which instituted guaranteed issue requirements aimed at improving the availability of group health insurance to small-employers. Other reforms have involved: restricting premium rates charged to small-employers by creating a rating band within which small group rates must remain and provided a premium tax exemption for; requiring insurers that offer health care insurance to medium and large employers to also offer it to small-employers; and exempting Accountable Health Plans from the premium tax for the reported small group premiums.
- Premium Sharing Program, implemented in 1998 provides health care coverage to a limited number of uninsured individuals with income up to 250% of FPL or below 400% of FPL, if chronically ill.
- KidsCare (Title XXI), implemented in 1999, to provide coverage to SCHIP eligible children up to 200% of FPL.
- Voter passed initiatives to target use of 70% of tobacco tax monies for health care to low-income uninsured groups (passed in 1994) and the expansion of AHCCCS coverage to all Arizonans below 100% of FPL through the use of tobacco settlement monies (passed in 2000). (See section below on recent public program expansions)

Understanding Cost Drivers

Since benefit design is considered to be one of the key determinants of the level of participation in health insurance program, William M. Mercer, Inc. analyzed the Arizona Basic Health Benefit Plan along with the proposed basic plan being informally discussed among the Task Force

member. (see *Arizona Basic Health Benefit Plan: A Comprehensive Review*). The report found that the Arizona Basic Health Benefits are:

- Not basic.
- Not targeted at the uninsured.
- Not affordable.
- Not attractive since consumers are currently not showing much interest in purchasing the product.

So that the Task Force could better understand the role that administrative costs plays in contributing to the cost of health care, William M. Mercer prepared a short paper on *Health Insurance Administration Costs* in which they noted that:

- Typical administrative functions include claims processing, network development and maintenance, case management, actuarial services, medical management, data collection and analysis, marketing and administrative management.
- The level of administrative expenditures is dependent on breadth of services offered, special needs of the population, size of the plan, regulatory requirements, and efficiency in administering the plan.
- While administrative expenditures have continued to increase in recent years they have decreased as a percent of total expenditures. For insurance plan types in 2000, the percentage of total expenditures spent on administration was 12 to 18% for indemnity or PPO, 12 to 20% for POS, 14 to 18% for commercial HMO and 10 to 21% for Medicaid HMO.

The Task Force also expressed concerned about the relationship between increases in health care cost and the impact it has on the purchasing of health care and/or insurance. In response William M. Mercer Inc. prepared a brief issue paper entitled. *Elasticity of the Demand for Health Care Services* and noted that:

- Demand for health care is considered to be inelastic – changes in price tend to have a small impact on changes in quantity.
- Similar to health care, overall health insurance is relatively inelastic (e.g. for every 1% increase in health care premiums there is an estimated 0.1% decrease of insured Americans).
- The Urban Institute found that for every 1% increase in premiums as a percentage of income, there is a corresponding drop in presentation of approximately 10 %.

It was felt that this last finding becomes of particular relevance when examining the experience of subsidized insurance programs targeted at low-income individuals.

Recent Marketplace Trends

Like the rest of the nation, after a very long period of economic growth, accompanied by moderate increases in the costs of health care, the Arizona economy has entered a period of

decline at the same time as health care costs have begun to increase rapidly. The Arizona health care marketplace is currently in a period of flux as health care costs continue to rise and the financial viability of some health care organizations continues to be threatened. The Center for Health System Change recently released their 2000 Community Tracking Study on the Phoenix health care market.[10] This report, despite its limited geographic focus does provide some valuable information regarding recent trends in the State's health care marketplace, many of which are applicable statewide. Some key trends that are noted in the report include:

- Consolidation of hospital systems; giving them more of a significant advantage in negotiations with health plans in geographic areas in which they have monopolies.
- Increase in physician discontent as reflected by the movement of specialists to specialty facilities and physicians refusing to enter into risk contracts.
- Increase in premiums and elimination of unprofitable or marginal lines of business to improve health plans financial conditions.
- Decrease in the number of Medicare+Choice health plans with those remaining requiring seniors to contribute more to the cost of care.
- Potential for deterioration of the local safety-net, which has been relatively stable over the past years.

These marketplace trends are further exemplified by a number of key events which have been recently reported in the local news. These include:

- Several health plans pulling out of the Medicare+Choice program, i.e., Aetna in Maricopa County (6200 enrollees), Pacificare in southern Pinal County (4100 enrollees) and several reducing benefits, e.g., Health Net Inc. and Humana Inc. This leaves only 3 out of 15 counties with Medicare+Choice plans.
- United Healthcare in Arizona dropping its individual health insurance product (7500 enrollees) in order to help regain profitability.
- The announced closing of the only two (2) trauma centers in Tucson; leaving southern Arizona which prompted the State legislature to appropriate $4.3 million to these centers for FY2002.
- Loss of $9.4 million in the past six (6) months by HMOs in Arizona with only two (2) out of six (6) of the major plans posting gains.
- Reported increases this year in health care premiums of 15 to 45 %; largely attributable to the posted losses in Arizona's managed-care companies.
- Reduction in employee choice of plans and out-of-pocket expenses, e.g., State of Arizona switched to one insurer to provide coverage to all state employees; at the same time increasing employee share for premiums and co-pays.
- Further erosion in health care services available in the rural areas of the State, e.g., January 2002 closing of Copper Queen Community Hospital's obstetrics wing in Bisbee, leaving only one hospital in Cochise County with obstetrical service.

The health care marketplace was also impacted by the enactment in 1999 of a state HMO reform law which gave patients various rights to appeal their health plan decisions. Part of this law expanded the number of legislatively mandated benefits. William M. Mercer, Inc. conducted an independent cost study in order to estimate the financial impact of health insurance mandates

recently enacted by the 1999 HMO reform law. The study considered mandates in six (6) areas: administration, access to medical supplies, pharmacy, direct access to care, emergency services and clinical trials. Taken together the estimated impact of the enacted mandates was a 5.7% increase in health care premiums. Direct access to chiropractic services had the greatest cost impact at 3%. (See the AHCCCS-HRSA Web site for a complete copy of the report which is entitled *Financial Impact of Recently Enacted Health Insurance Mandates*.)

In the Department of Insurance's recent evaluation of the Accountable Health Plan laws it found that in Arizona as in other states the small group market is shrinking.[7] The availability of group health insurance to small-employers has been adversely affected by the decease in the numbers of Accountable Health Plans. In 1999 there were 104 but as of December 31, 2001 there were 54. Of these it was estimated that probably only 27 were active in the small group market.

Finally, like the nation as a whole, Arizona is experiencing a workforce shortage in the health care field, especially in nursing. In a recent survey of Arizona hospitals, the Arizona Hospital and Healthcare Association found that the workforce shortages are contributing to emergency room overcrowding and diversion, reduced staffed beds, increased in surgery waiting time and cancelled inpatient and outpatient surgery. The Governor of Arizona has formed a Nursing Shortage Task Force to evaluate the issue and make recommendations to ensure an adequate supply of professional nurses in Arizona.

Rural Health Care Infrastructure

In order to more appropriately identify the issues that surround the development of a strong rural health care infrastructure and thus viable marketplace, AHCCCSA sought to provide the Task Force with additional information regarding the issue of rural infrastructure strategies. This effort resulted in:

- A policy brief by William M. Mercer, Inc., *Initiatives to Improve Access to Rural Health Care Services*, which found:

  - Information showing that rural uninsured tend to be employed by small-employers, reside in households with at least one full-time worker, are older, younger and poorer and have fewer provider network choices.
  - Identification of key barriers include: lack of physicians and other providers, geographic isolation and hospital solvency issues (i.e., insufficient volume to justify size and capabilities).
  - Discussion of strategies employed by other states to address rural infrastructure concerns and provisions including: financial and technical assistance to make rural areas more attractive to practitioners, examples of collaboration between health and non-health resources and/or urban and rural resources, changes in reimbursement methodologies for hospitals, and creative use of hospital space and resources.

- An AHCCCSA prepared document, *Inventory of Arizona Strategies to Address Rural Health Care Infrastructure*, provides a comprehensive description of specific strategies/programs that have been implemented in Arizona. These strategies have been grouped according to those which:

  - Increase the number of rural practitioners.
  - Minimize geographic isolation.
  - Improve the viability of health care facilities.
  - Financially support rural-based health care service programs.

Other States' Experiences

Other states' experiences, along with international approaches to health care delivery, have and continue to play an important role in the policy deliberation regarding health care coverage in Arizona. In order to educate policy makers regarding experiences outside of Arizona, five issue briefs were prepared (4 by Milliman USA, Inc. and 1 by William M. Mercer, Inc.) A summary of the findings from these papers is provided below:

- *Purchasing Pools* found:

  - Historically, challenges faced by pools have involved: low employer enrollment, lack of health plan participation, unwillingness of agents to promote, adverse selection, and the inability to offer PPO and POS plans.
  - Need to substantially increase the enrollment in pools in order to be viable and be able to offer lower prices.
  - Not able to lower prices enough to encourage more small-employers to offer insurance without significant subsidies or mandates.

- *High-Risk Pools* found:

  - Risk pools play a major role in making coverage available to uninsurable individuals, reducing the number of uninsured and providing stability to the health care market.
  - A key issue in establishing a high-risk pool is to make sure that it is well-funded including revenue sources besides premiums and assessments.

- *Implementation of Incentives and Regulatory Mandates to Increase Health Insurance Coverage* found:

  - SCHIP and premium sharing programs have been successful in enrolling targeted populations, although crowd-out may be a concern.
  - Tax credits and deductions are questionable for the uninsured and may be more appropriate to discuss at federal levels.

- Small group market reform has led to stability, more readily available and more predictable cost increases, but has not addressed the affordability issue and has had little or no impact on the number of uninsured.
- Individual market reform has not been successful in reducing the number of uninsured.
- Programs which are successful in reducing the number of uninsured generally involve some expenditure of public funds.

- *International Approaches to a Socialized Insurance System* found:

  - These systems are largely reliant on taxation, highly regulated, place a significant emphasis on preventative care, require co-pays and ration care through waiting lists.
  - To implement this type of system in US/Arizona, one would need significant increases in taxes to cover the uninsured, mandatory employer-based coverage, ERISA exemption, more uniformity of benefits, more regulation of provider fees, restrictions on patient choice of provider and income-based differentiation of benefits and/or contributions.

- *Review of Self-Insuring of Health Benefits and State Employee Health Plan Self-funding Survey* found:

  - Self-insurance allows employers to eliminate insurance profit and risk charges and take control of plan design with the flexibility staying with the employer. The disadvantage is that assets may be exposed to legal liability due to self-funding and monthly cash flow can fluctuate.
  - Successes of self-funded plans are linked to constant monitoring and assessment of costs and utilization, willingness to make changes when needed, selection of" best of breed" providers, targeted contracting with networks/providers for deep discounts, strong utilization and case management programs in place.
  - Sixty-eight percent of the states, self-fund at least one of their medical plans for state employees and five (5) more are considering self-funding. Sixty-two percent fully-insure their HMOs while self-funding indemnity, PPO and other types of plans. None include self-funded employee plans as part of a larger statewide health insurance reform or expansion initiatives. Seventy-four percent allow other groups to participate, e.g., counties, cities, towns, political subdivisions, school districts.

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

Due to the current State budget crisis (i.e., $1.2 billion shortfall for FY2003) serious consideration of options to expand coverage which required state funds was not feasible at this time. Additionally, the State recently undertook a major Title XIX coverage expansion with the implementation of Proposition 204 and subsequently received federal approval in December to add parents of Title XIX/XXI children between 100 to 200 % of FPL. Given these factors the State's focus was placed on trying to maintain those programs that have proven to play an effective role in making health care coverage accessible and affordable and to continue the development of a framework for the implementation of strategies addressing the issue of accessible and affordable health care in Arizona.

In addition to providing an overview of the recent Title XIX/XXI program expansions as well Title XIX/XXI outreach and enrollment strategies, this section presents the final recommendations of the Statewide Health Care Insurance Plan Task Force.

Recent Public Program Expansions

In the course of the State Planning Grant funding period there were a number of public program expansions which were both implemented and legislatively adopted by the State. As a result, AHCCCSA continues to expand its role in the delivery of public sponsored programs through both the implementation of new programs as well as the expansion of current programs. These changes include the following:

- Implementation of Proposition 204 on 10/1/01 which amends AHCCCSA's 1115 waiver and establishes Title XIX eligibility up to 100 % of FPL for individuals without children. It also has a spend-down component (e.g., MED) that enables individuals who have incurred medical bills to use those bills to spend down their income and become eligible for health care. Additionally, as part of the implementation of these groups, AHCCCSA is streamlining eligibility.
- Expansion of Title XIX eligibility for families with children through a State Plan Amendment which raises income eligibility for 1931 Title XIX eligibility group up to 100% of FPL beginning 7/1/01.
- Expansion of Premium Sharing Program from a four (4) county pilot to a permanent statewide program. Funding level for the program is an annual appropriation of $20 million.
- Modifications to KidsCare program (i.e., SCHIP), effective 10/1/01 which expands the benefit package (i.e., adds non-emergency transportation, removes eyeglass/exam and behavioral health limitation) and reduces the bare period from six (6) to three (3) months with the ability to waive if a child is seriously/chronically ill.
- Implementation of Breast and Cervical Cancer Treatment on 1/1/02 which adds a new Title XIX eligibility group of women under 65 who have been screened by Arizona

Department of Health Services (ADHS), have no insurance and need treatment for breast and/or cervical cancer.

As a result of the Title XIX program expansions and the slowing economy, AHCCCSA is currently projecting a 20% growth in the AHCCCS population this year. Currently, AHCCCS has 748,689 members. It has been estimated that between 137,000 to 185,000 individuals will be added to the AHCCCS program as a result of Proposition 204. Additionally, with the implementation of KidsCare, AHCCCSA has experienced a wood work effect (people who are eligible for a program but not enrolled until they "come out of the wood work" to apply for another program). Although 55,401 kids are enrolled in KidsCare, there are actually almost 148,160 children who now have health insurance as a result of the KidsCare program.

HIFA Waiver Approval

In December CMS approved Arizona's Health Insurance Flexibility and Accountability (HIFA) waiver to expand coverage beginning October 1, 2002 to parents of Medicaid and SCHIP children with family income between 100 to 200 % of FPL. While the intent is to enroll these eligible parents into the current AHCCCS program (i.e., AHCCCS capitated health plans), AHCCCSA is currently exploring the feasibility of also implementing an employer sponsored insurance pilot program. With the support of the State Planning Grant AHCCCS is slated to complete this feasibility study by late spring.

Budget Impact on Expansion Programs

Unfortunately, due to the current budget crisis there are two "expansion" programs that the State enacted last year in which the implementation of the programs has been reconsidered. This includes:

- Implementation of a state-funded Prescription Drug Pilot Program which would have reimbursed 50% of the cost of prescription medication in excess of a deductible for individuals who qualify for Medicare, have income levels between 100% to 200 % of FPL and who reside in counties with Medicare plans that do not offer a Medicare HMO pharmacy benefit. Two years of funding at approximately $4 million per year was originally appropriated but was subsequently eliminated during the recent Special Legislative Session to address the budget shortfall funding.
- Implementation of Ticket to Work on 4/1/02 which adds a new optional Title XIX eligibility group of individuals, 16 to 64 years of age who meet the SSI disability requirement and have earned income below 250% of FPL. It is still being determined whether funding for this program will continue beyond 06/30/02.

Title XIX/XXI Outreach and Enrollment Strategies

Over the past several years, the State has made a concerted effort to address the issue of eligible but unenrolled individuals in its Title XIX/XXI program. William M. Mercer, Inc. estimated that as many as 50% of the uninsured may be eligible for these publicly supported programs. The strategies employed have involved implementation of new outreach programs as well as changes in enrollment processes. A brief discussion of these strategies is provided below.

AHCCCS/Community Based Organization Outreach Project: AHCCCSA recently took a statewide grass roots approach to outreach by contracting with seven (7) community based organization (CBO's), e.g., county health departments, Association of Community Health Centers, and other provider organizations. The CBO's performed outreach to schools, clinics, CBO's, physicians, churches, tax preparers, day care centers and other sites. Their community partners educated potentially eligible families and children about the availability of all AHCCCS programs and assisted them in applying for AHCCCS services. The total combined contract amount for all seven (7) CBO's was $1 million and included funding for 35.5 outreach positions. Due to limitations in the budget, outreach is no longer funded through the CBO's, although some continue to perform outreach without funding. Outreach is now being conducted by AHCCCSA and special efforts are being made to continue ties with community-based organizations throughout the State.

General AHCCCS Outreach Activities: In addition to the CBO project described above, AHCCCSA has implemented a number of other outreach activities particularly targeted at individuals who may be eligible as a result of the various AHCCCS program expansions. All of the written materials and verbal announcements are provided in both English and Spanish. These activities include:

- A special $900,000 intensive six (6) month ad campaign for the KidsCare program which included radio, TV, brochures, posters and billboards conducted earlier this year.
- Radio advertising, bus shelter billboards and brochures targeted at the new eligibility groups under Proposition 204; including the 1931 eligible family and children group.
- Kiosk boards in malls where seniors walk in order to let them know about Title XIX and the enhanced benefits available under Title XIX.
- Sponsorship of events such as the Wellness Expo in Phoenix in November.

Streamlining of Eligibility Processes: As part of the recent program expansions, AHCCCSA has taken a number of key steps to address the ongoing goal of streamlining the Title XIX/XXI eligibility process. This includes the following:

- Universal AHCCCS Application. Instead of separate applications for each program, a universal application has been adopted, which is used to determine whether a person is eligible for any AHCCCS related program.
- Mail-in Applications. Effective 10/1/01 applicants are no longer required to come in for a person to person interview at a local Department of Economic Security (DES) office.

- Centralized Screening Office. A centralized screening office has been established at which AHCCCSA and DES staffs are co-located in order to help facilitate the processing of eligibility.
- Consolidation of Eligibility Entities. The counties will no longer be responsible for making eligibility determinations since eligibility functions are centralized at either DES or AHCCCSA depending on the eligibility group.
- Eligibility Re-determinations. Re-determinations for AHCCCS eligibility are conducted less frequently, by lengthening the redetermination period from six (6) to 12 months (except for the medical expense deduction group).

Border Vision Fronteriza: This RHO project which receives federal HRSA monies focuses on outreach efforts to enroll children into Title XIX/XXI in Santa Cruz, Pima and Yuma Counties. In its fourth year of funding it uses a community-based outreach model which relies on lay health workers to enhance access to health services by underserved US-Mexico border populations.

Baby Arizona: This program addresses the State's low rate of prenatal care through a public/private partnership. The goal of this outreach program is raise awareness about the importance of early prenatal care and use a streamlined eligibility process to get expectant mothers enrolled into AHCCCS.

Covering Kids Arizona: Through a Robert Wood Johnson Grant, the Children's Action Alliance is supporting state pilot projects related to community outreach and enrollment. The goal of this project is to learn what is necessary to fashion a strategy for increasing enrollment in health insurance programs for low-income children.

Statewide Health Care Insurance Plan Task Force Recommendations

One of the key outcomes early on from the Statewide Health Care Insurance Plan Task Force was the development of an agreed upon set of basic principles for health care coverage in Arizona which served as the framework for guiding the Task Force in the formulation of final recommendations. David Griffis, a consultant contracted with AHCCCSA, facilitated this discussion which resulted in four basic guiding principles:

- Health care, especially basic benefits should be available and accessible.
- Health care should be affordable and properly financed.
- Health care should be provided through a seamless system, offering the highest quality care.
- Health care should be done in collaboration and in cooperation with the various stakeholders, both public and private sector and it should foster competition.

Each of these guiding principles was accompanied by a set of specific questions (criteria) which were revisited through out the course of the Task Force's deliberations regarding a plan for implementation of strategies to address the issue of accessible, affordable health care in Arizona. (See Attachment A).

The Statewide Health Care Insurance Plan Task Force, which statutorily sunseted at the end of December, met one last time that month in order to finalize their recommendations as it related to the development of a plan/framework for the implementation of strategies addressing the issue of accessible, affordable health care in Arizona. Given recent coverage expansions through AHCCCS and the current budget shortfalls in the State, the Task Force acknowledged that while it is important to continue to look at the expansion of public programs, it would be difficult to implement any such strategies that involve the appropriation of new state monies at this time. However, the Task Force chairperson stressed that while it may not be possible to immediately implement agreed-upon strategies; there is a strong commitment to develop a plan as to how the system should look and then to build that system over time.

The Task Force recommendations fell into two broad categories: 1) Introduction of legislation to establish the Statewide Health Care System Task Force to examine defined public and private strategies for the implementation of an affordable and accessible statewide health care system and 2) Support for legislation to modify HealthCare Group, a small-employer health care insurance program in order to make it more financially viable. A more detailed description of these recommendations is provided below.

Creation of Frameworks and Statewide Health Care System Task Force

As adopted by the Statewide Health Care Insurance Plan Task Force, it was recommended that legislation be introduced during the January 2002 session which contained the following provisions:

- Changes the name of the Task Force to the Statewide Health Care System Task Force; adding three additional members (i.e., persons from House of Representatives, Senate and University of Arizona Health Science Center) and extending the life of the committee until December 31, 2004.

- Requires the Task Force to make recommendations to:

    - Narrow the gap between existing public and private health coverage programs through examining the feasibility of implementing:
        - Insurance reform to promote more accessible and affordable coverage options, especially those targeted at the individual and small group markets (e.g., HealthCare Group).
        - Consumer and employer education initiatives on the value of health care coverage and existing options within the private marketplace.
        - Private-public coverage programs such as high risk pool, full cost buy-in program or a premium assistance employer buy-in program.
        - Program for cooperative purchase of employee healthcare benefits by small group employers.

- Restructure current state employee and retiree health care coverage programs (e.g., self-insurance system and expansion of pool size).

- Enhance existing public supported programs through:

    - Support of effective outreach programs.
    - Coverage of parents of Title XXI children expansion of coverage groups.
    - Development of a plan to expand Title XIX coverage groups through state plan amendments.

- Improve the rural health care infrastructure through a variety of strategies including:
    - Continuing to support safety-net providers.
    - Fostering volunteerism and engaging the services of retirees from the health care professions.
    - Encouraging competition between health care service providers.
    - Increasing accessibility to medical services.
    - Developing a plan to more effectively coordinate current rural health care resources and programs.

This proposed legislation was introduced in both the Senate and House this January. Three bills have been introduced: SB 1056, HB 2286, and HB 2136.

Modifications to HealthCare Group

While the current economic climate in Arizona does not lend itself to the implementation of new programs, the Task Force felt that it was important to try and maintain those programs that have proven to play an effective role in making health care coverage accessible and affordable to Arizonans. To that end the Task Force supported the continuation of the HealthCare Group program and formally adopted a series of proposed changes to the program. These changes are based on recommendations set forth in the William M. Mercer, Inc prepared paper entitled *HealthCare Group – Moving Towards Accountability: A Proposed Plan.*

While HealthCare Group would continue to target the small-employer group marketplace between 1 and 50 employees and political subdivisions regardless of size, the adopted proposed changes included the following:

- Change the eligibility process for HealthCare Group by gathering sufficient household income information so that only those with no other public programs available to them are enrolled in HealthCare Group and have the ability to receive the state-only subsidies associated with the program.

- Streamline the benefit options offered under the managed care delivery system into a single uniform statewide coverage option including identical covered services, copays and benefits levels. Riders or other modifications would not be offered.

- Expand the HealthCare Group Administration to assume the primary responsibility for eligibility determination, enrollment and disenrollment with the HealthCare Group health plans focusing solely on the delivery and management of the care.

- Revise the underwriting methodology in order to develop a premium structure that uses an incremental scale based on employee age and household income. The scale can be coordinated with existing income eligibility guidelines for state and federal programs and can be set so persons with higher incomes will not receive state-subsidies.

The proposed changes to HealthCare Group were introduced as a bill in January in both the House (HB 2569) and the Senate (SB 1209).

SECTION 5. CONSENSUS BUILDING STRATEGIES

The very nature of the way in which the Arizona State Planning Grant was organizationally structured lent itself to a process by which one was able to effectively build consensus around the proposed framework and/or strategies. This is reflected both in the governance structure as well as the methods used to obtain key stakeholder input, which are further described below. Additionally, this section provides a brief overview of the current "policy environment" which is currently overshadowed by the State's budget crisis.

Governance Structure

The governance structure for the Arizona State Planning Grant effectively involved the executive branch, the legislative branch, and a variety of key constituent groups in the planning process. This is reflected by the following:

- AHCCCSA. The Governor of Arizona identified AHCCCSA, the state's Medicaid agency and overseer of a number of other subsidized insurance programs as the lead project agency. Phyllis Biedess, AHCCCS Director, served as the principal investigator for the project. Other AHCCCSA staff were also selected to be part of the project team. Michal Goforth filled a key role as the AHCCCS-HRSA Coordinator. Two new positions were established as a result of the grant: project administration associate and provider relations/model development specialist. Lisa Dominguez and Anna Shane respectively were hired into these positions. In addition to these three individuals, C. J. Hindman, M.D., AHCCCS Chief Medical Officer and Lynn Dunton, Assistant Director of Policy were identified as key AHCCCS advisors; providing ongoing guidance with regard to the project direction. Aside from AHCCCSA staff, AHCCCSA contracted with Linda Huff Redman, Ph.D., a management health care consultant to serve as the Project Director and David Griffis, Griffis Consulting, to serve as a facilitator for various project related meetings, e.g., Task Force meetings.

- Task Force. Through the grant, AHCCCSA provided technical and staffing support to Arizona's Statewide Health Care Insurance Plan Task Force, a legislatively sponsored committee, which was charged with the responsibility of designing an accessible and affordable health care coverage plan; including the identification of recommended strategies to be implemented. There were six (6) legislators on this committee representing both rural and urban districts in the State. In addition, other key constituent groups are represented on the Task Force including a member who is a health care provider, a representative of a consumer advocacy group and a member who represents the business community. These three (3) members were appointed by the Governor.

- Technical Advisory Committee. Key stakeholder input through the establishment of the Technical Advisory Committee which was composed of representatives from the physician community, insurance companies (urban/rural, commercial and specialty), hospitals (rural and urban) and state agency directors of AHCCCSA and Department of Insurance. This Committee provided AHCCCSA and the Task Force with guidance in the development of options as well as feedback on proposed strategies.

A more detailed explanation of individual roles and responsibilities related to the organizational structure can be found in the Project Schema for the State Planning Grant in the Executive Summary Section of this report.

Stakeholder Input

In addition to the various constituent groups that were part of the governance structure, the Task Force provided opportunities for the public to participate in a number of ways. In addition to the State Planning Grant-related presentations, numerous other formal presentations were made by other local health care experts, e.g., telemedicine, state employee insurance plan. All the Task Force meetings were well attended (i.e., approximately 50 attendees) with representatives from insurance carriers, retirement groups, advocacy agencies, employee unions, hospital association, health facilities and county governments. Additionally, public testimony was provided by numerous individuals including:

- Arizona Bridge to Independent Living
- American Association of Retired Persons
- Arizona Citizen Act
- Community Physicians
- Arizona Pharmacy Association
- Arizona Interfaith / Valley Interfaith

Finally, with the extension of the State Planning Grant for another year, AHCCCSA plans to conduct interviews with targeted groups of rural health care practitioners around the state. The purpose of these interviews will be to clearly identify both the barriers that discourage providers from practicing in rural areas as well as effective strategies for further developing the rural provider network. This work is slated to begin in late spring.

Other Public Awareness Strategies

In order to facilitate the public's easy access to AHCCCS-HRSA State Planning Grant information and project materials, AHCCCSA established a Web site (see www.ahcccs.state.az.us/Studies/default.asp?ID=HRSA). On this Web site, one can find general descriptive information about the project, Technical Advisory Committee minutes, policy issue papers, Task Force guiding principles, project contacts and links to state/federal related Web sites.

In addition to establishment of the Web site, AHCCCSA has made several public presentations regarding the AHCCCSA-HRSA State Planning Grant. This has included:

- Presentation and participation on a panel at the annual Arizona Rural Health Conference entitled "*Building Rural Health Networks*". Over 100 individuals attended this session; representing a diverse interest group, e.g., local community provider agencies, state officials, Indian tribes, and county public health departments.
- Presentation at a meeting of the four (4) Arizona Community Access Program grantees and one (1) rural Health Network Development Project grantee.

AHCCCSA also ensured direct lines of communication with other entities/organizations with overlapping interest, e.g., Community Access Program grantees; St Luke's Initiative and Collaboration for a New Century – Health Coverage Options Subcommittee. The health Coverage Options Subcommittee is using the work of the State Planning Grant to move forward their agenda to promote outreach and education, insurance for small-business and state employee insurance reform.

Current "Policy Environment"

As mentioned in Section 4, the State of Arizona has a severe budget shortfall, which has had and continues to have an enormous impact on the type of coverage expansion strategies that will be adopted in the State in the near future. Some analysts have estimated that the deficit could be as high as $2 billion for FY2002 and FY2003. The State Legislature was called into special session in December which resulted in a reduction of approximately $800 million to the State's FY2002 budget. Another special session occurred in 2002 where an additional $200 million reduced the State budget. Along with across the board reductions in state agency budgets, numerous other budget reduction strategies were enacted which impacted health care programs. One such area was reduction in programs funded with tobacco tax monies, e.g., a non-Medicaid prescription drug benefit, children's behavioral health services, and community health centers capital project grants.

As part of the current legislative session, the Legislature just completed another special session in order to cut an additional $220 million from the FY2002. With the budget deficit resolved for FY2002, they will now have to address the $1.2 billion budget deficit for FY2003. The budget cut decisions are clearly becoming much more difficult to make. All avenues are being explored, including elimination of certain health care programs, reducing Title XIX/XXI health care benefits as well as avenues which will allow maximization of federal funds, and capping state spending associated with Proposition 204.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

Overall, AHCCCSA found the State Planning Grant to be a very effective means by which to facilitate and focus the State's policy discussion as to how best to address the need for accessible and affordable health care coverage in Arizona. The end result of this effort was an increased understanding of the issues surrounding health care coverage and the uninsured and the development of a framework within which to work on the development of specific strategies.

This section discusses some of the lessons learned in the operationalizing of the State Planning Grant with the hope that these may prove to be of value to new State Planning grantees when designing their projects.

Data Collection

Unlike most other State Planning Grant states, Arizona made a conscious decision up front not to put as heavy an investment in the collection of extensive primary data regarding current coverage and coverage barriers (e.g., statewide surveys and focus groups). There were several reasons for this decision. It was felt that while it was important to be able to understand the current health care coverage landscape, grant monies also needed to be available for the gathering of information on other states' experiences, educational materials on health coverage issues, in-depth analysis of any proposed strategies, including the financial analysis and solicitation of stakeholder input on the potential strategies. In trying to balance out the various needs, an extensive state specific survey was ruled out due to the high cost and long length of time associated with it. Instead, it was decided that an adequate picture of the current landscape could be obtained through existing data sources, e.g., national surveys and local data sets. Additionally, through literature reviews (e.g., national studies as well as other states' data surveys) fairly consistent patterns have been emerging in terms of health coverage demography and coverage issues. Since the project focus was the development of a general plan at the state level it was felt that despite recognized data limitations, reliance on secondary data sources would result in an accurate enough picture with which to be able to make appropriate decisions. Lastly, while AHCCCSA was able to effectively draw from secondary data and information available nationally and locally, it was recognized that state specific data collections will become more critical in the future as the State evaluates and develops specific strategies/proposals.

While beyond the scope of Arizona's project, the results of a recent study funded by the Phoenix-based Flinn Foundation (i.e., Yuma Project on Uninsured Children) may be of interest to other states focusing on specific strategies targeted at the local community level.[11] This study found that a community health data system as opposed to survey data can be used to provide accurate estimates of the numbers of uninsured children in small geographic areas and at a relatively low cost. This community data is also dynamic in that it can be continuously updated

at a relatively low cost; providing unique information on health coverage at points in time and on patterns of health care utilization and changes in needs and insurance over time.

Organization Structure and Consensus Building

As mentioned above, AHCCCSA believes that the project organizational structure which was put in place at the beginning was very effective for achieving the planning grant goals. Due to the complex nature of the subject education of the Task Force members as well as the public prove to be a critical component for developing the framework for future decisions regarding coverage strategies. The approach of using both a legislatively formed Task Force balanced with a Technical Advisory Committee appeared to offer a good balance between the political decision making process and more expertise-based decision making. Finally without the legislative involvement from the beginning it would have been more difficult to garner such immediate support for continuing the effort beyond the grant period as well as sponsoring legislation which supports the Task Force recommendations.

Other Issues

There were a number of other issues that AHCCCSA believes are important for states to consider as they begin to operationalize their State Planning Grants. These include:

- Before re-inventing the wheel, do a careful review of the information (e.g., reports, surveys) that is already available both nationally and locally. There is a surprising amount of data and information out there on the subject some of which has simply not been well publicized.
- Take advantage of the technical resources that are available through the State Planning Grant (e.g., Academy for Health Services Research and Health Policy, State Health Access Data Assistance Center) as well as the knowledge and work of the other State Planning Grant states.
- Be realistic about what one can accomplish in a year, everything takes longer than expected. For Arizona it took the entire year just to establish the framework.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

It is important for the Federal government to recognize that states' ability to expand coverage and develop a seamless system of care which is accessible and affordable is hampered by the Federal Government in its role as both a regulator of self-insured plans and an administrator of major coverage programs, e.g., Medicare, Indian Health Service, and Veterans Affair. This situation gets further exasperated with the continual passage by Congress of body part language. Additionally, if states are to be successful in their efforts to expand coverage the Federal Government needs to work in close partnership with the states to:

- Allow more flexibility in the operation of programs such as Medicaid and SCHIP
- Provide federal financial support for coverage expansions such as subsidies for low-income individuals.
- Make available better national survey data that is both timely and state specific especially with regard to employer-based coverage. This should involve providing ongoing support for the Integrated State Database developed by Arkansas as part of the State Planning Grant process.
- Continue to fund state research on the uninsured including the development of strategies to prevent erosion of current coverage programs given the current economic environment.

It is only through this type of federal-state partnership that the issue of health care coverage in Arizona and the nation as a whole can be effectively addressed.

APPENDIX I: BASELINE INFORMATION

Population

According to the Census 2000 Supplementary Survey, Arizona's total population in 2000 was estimated to be 5,020,782.[12]

Number and Percentage of Uninsured (Current and Trend)

In Arizona, the percentage of people without health insurance coverage has decreased over the past three (3) years. According to the U.S. Census Bureau, in 1998, 22.5% of the population was uninsured; in 1999, 20.0% of the population was uninsured; and in 2000, 16.0% of the population was uninsured. The 3-year average from 1998-2000 is 19.5%.[1]

Average Age of Population

As noted by the Census 2000 Supplementary Survey, the median age in Arizona is 34.3 years-old.[12]

Percent of Population Living in Poverty (<100% FPL)

The Census 2000 Supplementary Survey estimated that 15.6% of Arizona's population is living below poverty level. For people over 18 years and older, 13.1% are below poverty level. For people who are 65 years and older, 9.5% are below poverty level. For related children under 18 years, 22.0% are below poverty level. For related children under 5 years-old, 25.3% are below poverty level. For related children five (5) to 17 years, 20.8% are below poverty level. For unrelated individuals 15 years and older, 23.0% are below poverty level.[13]

Primary Industries

The Census 2000 Supplementary Survey also reported that the three primary industries in Arizona in order from highest to lowest are: services, retail trade, and manufacturing. [13]

Number and Percent of Employers Offering Coverage

The Health Insurance Component Analytical Tool (MEPS) reported that in 1999, there were 95,133 private-sector establishments in Arizona. Of the 93,910 employers, 50,430 (58.8%) of them offered health insurance.[14]

Number and Percent of Self-Insured Firms

In 1999, there were 30,157 (31.7%) private-sector establishments in Arizona that offer health insurance that self-insure at least one plan according to MEPS.

Payer Mix

The US Census Bureau estimated that in 2000, 84% of the Arizona population had health care coverage. 59.2% were covered by an employer-sponsored plan, 67.7% were covered by individually purchased private insurance, 10.4% were covered by AHCCCS, 12.5% were covered by Medicare, and 4.4% were covered by other federal programs.[15]

Provider Competition

The Winter 2001, *Community Report* summarizes the recent provider competition among hospitals, physicians, and health plans in Phoenix. As a result of the rapid growth, national firms now control 70% of the Phoenix community's hospital capacity, as well as dominate the health plan market. Many hospitals are trying to affiliate themselves with national systems in order to come up with capital necessary to keep up with the increase in demand (e.g., the merger between Samaritan Health System, the area's largest provider system, and the national Lutheran Health Network to form BannerHealth Arizona). Many hospitals focus their strategies on certain geographic areas, which helps them to secure better contract terms and higher payment rates. As a result, this also limits health plans' ability to hold down costs.

The report also notes the shifting of physicians from traditional hospitals to specialty facilities. Due to their discontent with local health care systems and desire for higher incomes, physicians are leaving traditional hospitals with the loss of profitable services. In addition, hospitals are finding it increasingly difficult to provide emergency room and on-call coverage as physicians attempt to avoid seeing uninsured patients for whom they will not be reimbursed. This has led to some specialists forming arrangements to demand above-market reimbursement. The relationship between physicians and health plans has also become more difficult as physicians are refusing to enter into risk contracts, and health plans are reverting to fee-for-service payment.

Out of the ten (10) HMOs currently operating in Phoenix, only two (2) of those have reportedly been profitable. In an attempt to become more profitable, plans have been increasing premiums and eliminating unprofitable or marginal lines of business. As a result of the struggle for profitability, several health plans are pulling out of the Medicare+Choice program, which has left only three (3) out of 15 counties with Medicare+Choice plans. Low profitability and recent regulations may be why many consumers have seen higher costs and fewer choices.

Insurance Market Reforms

The Arizona Department of Insurance (DOI) has compiled the following information on insurance market reforms. There have been several key health care insurance reforms in Arizona over the last eight (8) years. In 1993, the legislature enacted the Accountable Health Plan Law, which was aimed at improving the availability of group health insurance to small-employers.

Effective January 1, 1994, group health insurers (Accountable Health Plans) were required to offer at least a basic health benefits plan to employers, including small-employers. The legislation phased in elements of guaranteed issue with later effective dates. Specifically, effective July 1, 1994 an Accountable Health Plan was required to make the basic health benefits plan available to employers with 25 to 40 employees who had been without coverage for at least 90 days. Effective July 1, 1996, an Accountable Health Plan was required to make the basic health benefits plan available to employers with three (3) to 40 employees who had been without coverage for at least 90 days.

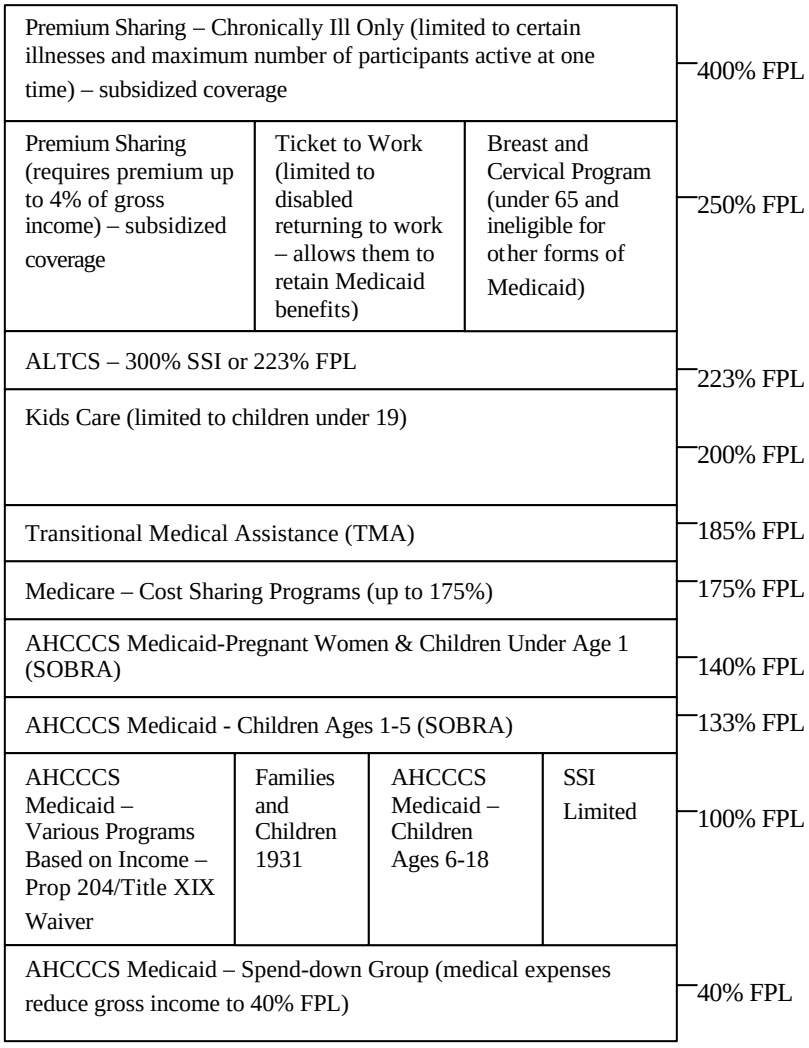
While the 1993 legislation improved the availability of group health insurance to small-employers, it only provided such coverage on a guaranteed issue basis for a certain small-employers and their employees. Legislation that became effective July 1, 1997 required an Accountable Health Plan to provide a health benefits plan, without regard to health status-related factors, to any small-employer who agreed to make the required premium payments. As part of this legislation the definition of "small-employer" was revised to include any employer with two (2) but not more than 50 employees, the basic health benefit plan was eliminated and all small-employers are entitled to guaranteed issue, not just those that have been without coverage for at least 90 days. This legislation conformed to federal guaranteed availability requirements established in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Another aspect of small-employer market reform was enacted in 1996 and that was the granting of a premium tax exemption for Accountable Health Plans for reported small group premiums. (All insurers in the state including Accountable Health Plans must pay a two percent tax on their premiums). Some Accountable Health Plans have determined that the tax savings is not worth the administrative cost of breaking out the small-employer premiums and do not claim the exemption.

Finally, in 2000 the Arizona legislature passed legislation restructuring the regulatory oversight of managed care organizations, mandating additional health care benefits and establishing timely pay and grievance standards for payment of health care providers.

Eligibility for Existing Coverage Programs

Please see the chart on the following page for eligibility levels for income-based programs:



Use of Federal Waivers

Arizona became the last state in the nation to implement a Medicaid program. In October 1982, Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS) was started under an 1115 Research and Demonstration Waiver granted by the Health Care Financing Administration (HCFA). From 1982 until 1988, AHCCCS only covered acute care services, except for a 90-day post-hospital skilled nursing facility coverage. Then, in 1988, a five (5) year extension of the program was approved by HCFA to allow Arizona to implement a capitated long-term care program for the elderly, physically disabled, and developmentally disabled populations – the Arizona Long Term Care System (ALTCS). In 1990, AHCCCS began offering comprehensive behavioral health services, eventually extending behavioral coverage to all Medicaid eligible persons over the next five years. Since then, a number of waiver extensions have been approved; including approval in January 2001 of a waiver which allowed Title XIX eligibly to be increased to 100 % of FPL. One recent approval was in

December 2001 which extended the demonstration waiver until September 30, 2006. Additionally, this waiver allows the State to use Title XXI funds to expand coverage to two populations 1) adults over 18 without dependent children and below 100 % of FPL and 2) individuals between 100 to 200 % of FPL who are parents of children enrolled in Title XIX/XXI.

The most recent waiver approved by CMS was the Health Insurance Flexibility and Accountability (HIFA) waiver to expand coverage to parents of Medicaid and SCHIP children with family incomes between 100 to 200% of FPL. Coverage will begin October 1, 2002.

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

The key Web Site to use for additional sources of information regarding the AHCCCS-HRSA State Planning Grant is www.ahcccs.state.az.us/Studies/default.asp?ID=HRSA.

NOTES

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4. "Health Care in Arizona, 1995 vs. 1989" Studies of Health Care in Arizona by Louis Harris and Associates [online] (published in 1996 [cited 19 March 2002]); available on the Flinn Foundation Web Site from http://www.flinn.org/news/reports/.

5. Diane Pearce, "The Self-Sufficiency Standard for Arizona" issued by Children's Action Alliance. March 2002; available http://www.azchildren.org/caa.

6. "Squeezing the Rock: Maricopa County's Health Safety-net" Arizona Health Futures, St. Luke's Health Initiatives. Winter 2002; available from http://www.slhi.org/ahf/studies.

7. "Uninsured and At Risk: Coverage Profiles and Trends Among 10 States." Task Force on the Future of Health Insurance. Prepared for the National Summit on the Uninsured September 8, 2000; available from the Commonwealth Fund by calling 1-888-777-2744.

8. WestGroup Research. "Small-Business Survey Arizona 2000" prepared for Arizona Hospital and Healthcare Association, Arizona Chamber of Commerce, Blue Cross and Blue Shield of Arizona and St. Luke's Charitable Health Trust; available from http://www.azhha.org/public/pdf/small_bus_full_rpt.pdf.

9. "Triennial Report Regarding the Accountable Health Plan Laws" Arizona Department of Insurance. 2002.

10. Draper, Debra, et al. Rapid Population Growth Attracts National Firms, Phoenix Arizona. Community Report, No.04 (Washington, D.C.: Center for Studying Health System Change, Winter 2001).

11. School of Health Administration & Policy, College of Business, Arizona State University, "The Yuma Project on Uninsured Children", Report to the Community. September 17, 2001.

12. Profile of General Demographic Characteristics: 2000." Census 2000 Supplemental Survey Summary Tables [database online] (2000 [cited 19 March 2002]); available from http://www.factfinder.census.gov/servlet/BasicFacts/servlet.

13. "Profile of General Selected Economic Characteristics: 2000." Census 2000 Supplemental Survey Summary Tables [database online] (2000 [cited 19 March 2002]); available from http://www.factfinder.census.gov/servlet/BasicFacts/servlet.

14. "Health Insurance Component Analytical Tool (MEPSnet/IC)" Agency for Healthcare Research and Quality, Rockville, MD. [database online] (January 2001 [cited 19 March 2002]); available from http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.asp.

15. "Historical Health Insurance Tables" U.S. Census Bureau [database online] (2000 [cited 19 March 2002]); available from http://www.census.gov/hhes/hlthins/historic/hihistt4.html.

ATTACHMENT A:

FINAL REPORT OF THE STATEWIDE HEALTH CARE INSURANCE PLAN TASK FORCE

Attachment A

FINAL REPORT

STATEWIDE HEALTH CARE INSURANCE

PLAN TASK FORCE

December 2001

Membership

Senator Edward Cirillo
Co-Chair

Representative Jim Carruthers
Co-Chair

Senator John Verkamp
Senator Virgina Yrun

Representative Linda Binder
Representative Robert Cannell

Mr. Terry Cooper
Dr. George Burdick
Representative Tom O'Halleran
Mr. Erin Collins

TABLE OF CONTENTS

SECTION 1. INTRODUCTION

This final report summarizes the efforts of the Statewide Health Care Insurance Plan Task Force (Task Force) during the past year. The report is divided into four sections. In addition to an overview of the report format, this introductory section provides background information regarding the purpose of the Task Force and its membership. This section is followed by Section 2, which contains a general overview of the Task Force activities and accomplishments. Section 3 sets forth the specific Task Force findings and recommendations. Lastly, Section 4 contains copies of all the handouts that were distributed at the Task Force meetings.

As required by the legislation this report is being submitted to the Arizona Speaker of the House of Representatives, the Arizona President of the Senate and the Governor for their review and consideration.

Purpose of Task Force

The Task Force, which was established pursuant to Laws 2000, Chapter 320, was charged with the task of developing an affordable and accessible health care insurance plan for all Arizonans. As part of this effort the Task Force was also required to undertake the following activities:

- Identify and assess potential insurance risk pools among residents of this State.
- Study and recommend timely and efficient reimbursement methods.
- Determine benefit levels.
- Review current national, state and local public health care plans.
- Review and analyze the role of state agencies and political subdivisions under a statewide health care insurance plan.
- Analyze health care insurance factors that vary among urban and rural areas and recommend ways in which these factors could be streamlined.
- Study and recommend ways to treat rural and urban areas in an equitable manner.
- Identify the various sources of monies to fund a statewide health care insurance plan.
- Explore alternatives that may be used to initiate a health care plan that would be available to and affordable for residents in both rural and urban areas.

Task Force Membership

As set forth in the legislation, the Task Force consisted of nine members: three members of the House of Representatives, three members of the Senate and three public members who are appointed by the Governor and who represent a health care provider, a consumer advocacy group and the business community. The following members were initially appointed in August 2000:

- Senator Cirillo, Co-Chair
- Senator Bee

- Senator Richardson
- Representative Carruthers, Co-Chair
- Representative Blewster
- Representative Nichols
- Dr. George Burdick
- Mr. Erin Collins
- Mr. Terry Cooper

While five of the committee members, i.e., co-chairs and public members, remained the same throughout the duration of the Task Force's existence, due to changes in the make-up at the Legislature, the following legislative members were appointed in the spring of 2001:

- Senator Yrun
- Senator Verkamp
- Representative Binder
- Representative Cannell
- Representative O'Halleran (ex-officio)

Pursuant to the legislation, the Task Force is repealed from and after December 31, 2001.

SECTION 2. TASK FORCE ACTIVITIES

Prior to formalizing its recommendations, the Task Force devoted a great deal of its time to educating themselves about health care coverage in Arizona, issues surrounding the accessibility and affordability of coverage and strategies that have been implemented in other states to address these issues. Along with this education process, the Task Force members spent time discussing the issue and possible solutions.

The Task Force was supported in their efforts by the $1.16 million State Planning Grant that the AHCCCS Administration (AHCCCSA) received from the Health Resources and Services Administration (HRSA), Department of Health and Human Services, in March 2001. The primary purpose of this grant was to facilitate the development of a plan for providing Arizonans with affordable, accessible health insurance, including technical and staffing support to the Task Force.

This section provides a general overview of the major activities undertaken by the Task Force. The activities described below have been grouped into the following three categories: Task Force meetings, policy briefing papers and data collection and public participation.

Task Force Meetings

Over the past year, the Task Force held eight meetings. These meetings served multiple functions, allowing Task Force members to hear formal presentations by experts in the community, to receive public testimony and to discuss key issues and solutions related to the provision of accessible and affordable health care coverage in Arizona.

Below is a brief description of the eight Task Force meetings. Actual meeting minutes for the Task Force can be found at http://www.azleg.state.az.us/iminute/iminutelinks.htm. In addition, handouts from the Task Force meeting can be found in Section 4 of this report.

- November 30, 2000: At this first meeting of the Task Force, the co-chairs reviewed the committee's purpose and goals. The rest of the meeting consisted of a series of formal presentations a number of which focused on the provision of health care in rural areas (e.g., problems in providing coverage, pull out of Medicare HMOs, cost factors). Information was also presented on risk pools and the role they play in addressing health care coverage issues. Lastly, overviews were provided on the Arizona HealthCare Group Program, Premium Sharing Demonstration Project and the Arizona Telemedicine Program.

- January 5, 2001: Similar to the first meeting, this meeting consisted of four formal presentations targeted at educating Task Force members about health care programs and coverage in Arizona. This included: (1) an overview of Proposition 204 and the implementation of increasing eligibility to 100 percent of the federal poverty level

(FPL); (2) a detailed description of the HealthCare Group Program and Premium Sharing Demonstration Project, including who is covered under these program; (3) a discussion of the health care marketplace in Arizona, identifying those populations with the greatest needs in terms of health coverage; and (4) an overview of the critical access hospital program being implemented in the State and the problems faced by rural hospitals in Arizona. Lastly, due to the magnitude of the health care coverage problem, Senator Cirillo presented a graphic presentation of the health care system in Arizona.

- May 14, 2001: Overviews were provided regarding relevant 2001 health care coverage legislation, the State Planning Grant and Medicaid expansion up to 100 percent FPL (i.e., Proposition 204 implementation). The key focus of the meeting was the development of an agreed upon set of basic principles for health care coverage in Arizona which are intended to serve as the framework for guiding the Task Force in the formulation of final recommendations. David Griffis facilitated this discussion which resulted in the identification of basic guiding principles along with a set of specific questions (criteria) to consider when developing strategies, models, etc. (See Section 3. Task Force Findings and Recommendations).

- August 23, 2001: AHCCCSA provided a brief update on the implementation of all the new expansion programs it will be implementing this year. The key focus of this meeting was the presentations by the AHCCCSA contracted consultants (i.e., William M. Mercer, Inc. and Milliman USA, Inc.) on the seven policy issue papers they had prepared. From these presentations, Task Force members discussed possible strategies for addressing the issue of health care coverage in Arizona including:

  - Targeting of small employer groups and individuals residing in rural areas of the state and the pre-retirement group.
  - Development of purchasing pools potentially building upon the existing HealthCare Group program.
  - Development of a high risk pool.
  - Development of additional strategies to address health care infrastructure issues in rural areas of the state.

- September 27, 2001: AHCCCSA presented a series of diagrams that portrayed health coverage in Arizona with a specific focus on publicly sponsored coverage and a diagram summarizing rural health care infrastructure strategies (see Section 4. Attachments). Based on Task Force inquiries William M. Mercer, Inc. presented follow-up information regarding the financial costs associated with recently enacted insurance mandates and demographic information on the sub-population of uninsured individuals 45 to 64 years-old. An update from the AHCCCS-HRSA Technical Advisory Committee was given which provided the Task Force with input on potential strategies being considered and setting forth some recommended strategies for the Task Force to consider.

- November 14, 2001: Two issues that were raised at the previous Task Force meeting (health insurance administration costs, elasticity of demand for health care) were addressed by William M. Mercer. In response to the Task Force interest in moving toward a self-insured program for state employees, William M. Mercer, Buck Consultants and Arizona Department of Administration made formal presentations on self-insured programs and state employee health care coverage. The Task Force reviewed a proposed draft of a statement of legislative intent, which ultimately served as the basis for proposed legislation. Clarification regarding the document was provided and members offered a number of suggested changes.

- November 26, 2001: The Arizona Association of Community Health Care Centers presented an overview of their 2002-2006 plan for expansion along with several recommendations to the Task Force (i.e., continuing to fund the primary care programs and clinic construction program and increasing funding for the state provider loan repayment program). A demographic overview of Arizona's population and health care coverage including characteristics of the uninsured population was presented by the Southwest Border Rural Health Research Center.

- December 11, 2001: Prior to discussing the proposed draft legislation, the Task Force listened to presentations that addressed follow-up issues raised by members. This included issues related to self-insurance, proposed HealthCare Group changes and additional demographic information regarding the uninsured population in Arizona. The key focus of the meeting was the review and discussion of the proposed draft legislation, along with the final adoption of recommendations (see Section 3 for a detailed discussion).

Briefing Papers and Data Collection

In addition to formal presentations by health care experts numerous briefing papers were prepared for Task Force members in order to help facilitate the identification of the most appropriate strategies for addressing the issue of affordable and accessible health care coverage. With the monies from the HRSA State Planning Grant, AHCCCSA contracted with a variety of consultants for the preparation of these briefing papers. The Task Force played an active role in determining the topics for these papers, which included a national perspective as well as a local focus.

National Perspective

For the national perspective ten policy issue papers were developed. These papers included, where appropriate, a summary of current approaches/best practices being used by other states and their experience, an evaluation of the pros and cons of the approach(es) in the context of the guiding principles developed by the Task Force and the identification of issues that need to be considered in adopting various approach(es). These papers are available on the AHCCCS-HRSA State Planning Grant web site www.ahcccs.state.az.us/Studies/default.asp?ID=HRSA.

These papers were completed by Milliman USA, Inc. (first four papers listed below) and by William M. Mercer, Inc. (last six papers listed below) and include:

- *Purchasing Pools* focuses on purchasing pools established for small employee groups and individuals/families and their effectiveness in improving access and affordability to health insurance.
- *High-Risk Pools* examines the types of risk pools implemented by other states to cover residents whose medical costs preclude them from obtaining coverage at affordable prices in the private market.
- *Implementation of Incentives and Regulatory Mandates to Increase Health Insurance Coverage* provides an overview of incentives that have been implemented by other states to increase private health insurance coverage as well as provides commentary on the effectiveness of legislative mandates at the state level. Strategies examined include: those targeted at the consumer (e.g., tax credits, premium sharing, discount cards), health plan/insurance company (e.g., premium tax, mandated rural coverage, premium regulation, limits on waiting periods) and employers (e.g., tax credits, mandated payroll deductions for those employees participating in health insurance program).
- *International Approaches to a Socialized Insurance System* provides a brief overview of the socialized medicine approach to the delivery of health care that has been operating in European and other select countries.
- *Faces of the Uninsured and State Strategies to Meet Their Needs* identifies and describes the key sub-populations that one needs to consider in addressing the issue of accessible and affordable health care coverage (e.g., low-income uninsured, working uninsured, rural uninsured) as well as a brief discussion of strategies used by states to address the needs of the specific sub-populations.
- *Initiatives to Improve Access to Rural Health Care Services* provides an overview of strategies that have been implemented by other states to increase access to health care in rural areas both in terms of increasing coverage and enhancing provider networks.
- *Arizona Basic Health Benefit Plan: A Comprehensive Review* examines the Arizona Basic Health Benefit Plan in the context of other states' approaches and critiques the plan in terms of benefit design variables as well as its overall affordability.
- *Health Insurance Administrative Costs* provides a brief discussion of the factors which impact administrative expenditures and provides percentages of total expenditures spent on administration by insurance plan types in 2000.
- *Elasticity of the Demand for Health Care Services* discusses the relationship between the demands for health care as it relates to the cost of care, arguing out that health insurance is relatively inelastic.
- *Review of Self-Insuring of Health Benefits* explains the features and differences between fully insured funding arrangements and self-insured funding, as well as minimum premium funding which is a combination of fully and self-insured.

Arizona Perspective

In addition to looking at strategies implemented in other states, a number of the briefing papers focused specifically on Arizona. These papers included the following:

- As a complement to the policy briefing paper developed by William M. Mercer, Inc. (*Initiatives to Improve Access to Rural Health Care Service*), AHCCCSA completed a paper which provides an inventory of the strategies that have been implemented in Arizona to address rural health care infrastructure issues.
- William M. Mercer Inc., completed a paper which examined the cost impact of recently enacted health insurance mandates in Arizona, e.g., direct access to chiropractic services, standing referral requirement and access to medical supplies.

In order to gain a more thorough understanding of Arizona's health care coverage and health insurance landscape, AHCCCSA engaged the University of Arizona, College of Public Health, Rural Health Office, Southwest Border Rural Health Research Center to analyze and compile information on:

- Population characteristics and employer composition at both the State and county level.
- Available health care coverage options in Arizona.
- Characteristics of Arizona's uninsured population.

This information was presented to the Task Force through two formal presentations made by the Southwest Border Rural Health Research Center.

Public Participation

Aside from the formal presentations by health care experts, the Task Force provided opportunities for the public to participate in a number of ways. The Task Force meetings were well attended (i.e., approximately 50 attendees) with representatives from insurance carriers, retirement groups, advocacy agencies, employee unions, hospital association, health facilities and county governments. Additionally, public testimony was provided by numerous individuals including:

- Arizona Bridge to Independent Living
- American Association of Retired Persons
- Arizona Citizen Act
- Community Physicians
- Arizona Pharmacy Association
- Arizona Interfaith / Valley Interfaith

Lastly, the Task Force members received public input from the AHCCCS-HRSA Technical Advisory Committee (TAC) established by AHCCCSA as part of the HRSA State Planning Grant. The TAC's purpose was to serve in an advisory capacity to both AHCCCSA and the Task Force, providing guidance in the development of plan options as well as feedback on

proposed approaches. The TAC was composed of representatives from the physician community, insurance companies (urban/rural, commercial and specialty), hospitals (rural and urban) and state agency directors of AHCCCSA and Department of Insurance. The TAC made a formal presentation to the Task Force at their September meeting. (See AHCCCS-HRSA project Web site for additional information about the TAC including the meeting minutes).

SECTION 3. TASK FORCE FINDINGS AND RECOMMENDATIONS

Early on in the process, the Task Force developed an agreed upon set of basic principles for health care coverage in Arizona which were intended to serve as the framework for guiding the Task Force in the formulation of their final recommendations. These guiding principles along with the Task Force's final recommendations are described below.

Guiding Principles

The Task Force agreed upon four basic guiding principles. These guiding principles are listed below along with a set of questions (criteria) to be answered when developing health care coverage strategies. The accompanying drawing (Diagram 1) summarizes these principles and restates the four fundamental beliefs of the Task Force.

Health care, especially basic benefits, should be available and accessible.

- Are the basic benefits (i.e., service coverage and limitations) clearly defined?
- Are the sub-populations eligible for coverage clearly defined including the coverage (or non-coverage) of non-US citizens?
- Are prevention services that will save money included as part of the basic benefit package? Can they be quantified?
- Will the benefit package provide the opportunity for improvement in health status and the delivery of quality care?
- Is the basic benefit package portable?
- What is the value (i.e., return on investment) of the basic benefit package?
- Does the package contain the appropriate incentives to support the guiding principles?
- Are the right services (plans and providers) available in the right places at the right times?
- Are there incentives in place to encourage providers to provide services where needed?
- Will consumers (e.g., employers, employees, non-employed individuals) use the services, i.e., minimal barriers and appropriate incentives?
- Do commercial carriers have the incentive to participate?

Health care should be affordable and properly financed.

- Have the costs been clearly identified, both short and long term?
- Have the associated financial risks been clearly identified?
- Can the State afford it? Can members afford it? Can carriers afford to offer it?
- Can the costs be appropriately managed?
- Is it financially self-sustaining and solvent over the long term?
- Does it foster and encourage consumer responsibility?

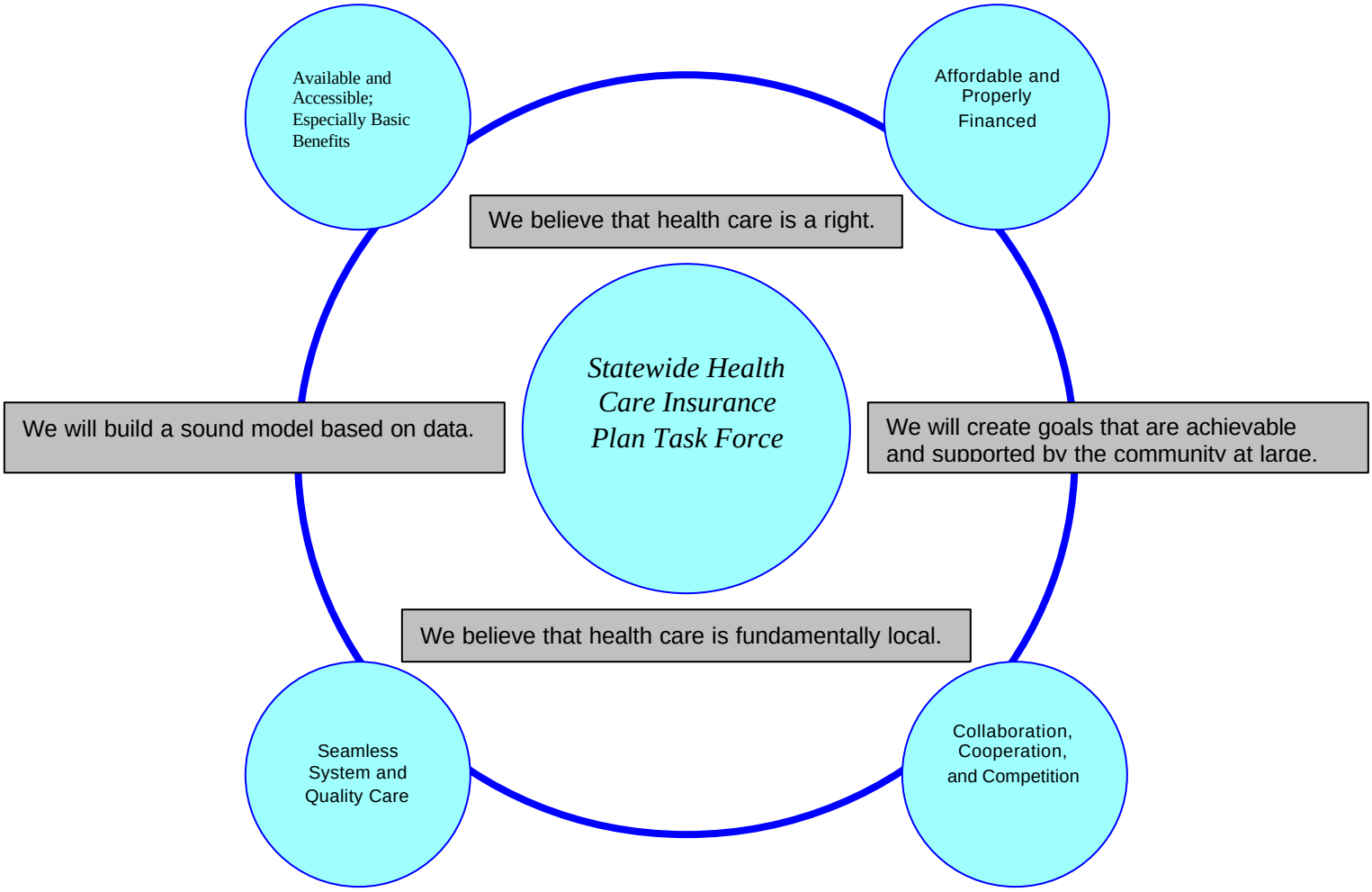
Health care should be provided through a seamless system, offering the highest quality care.

- Do pieces of the system fit together well minimizing fragmentation and duplication? Does interdependence and coordination exist between system pieces?
- Have the interrelationships between various programs been taken into consideration such as those sponsored by Title XIX/XXI, Mexican government, Indian Health Services.
- Is one stop shopping made possible in as many situations as practical?
- Are services/care coordinated including the ability to easily move from primary care to specialty?
- Is there the flexibility and adaptability to move pieces around?
- Does the system encourage the highest and best use of services?
- Does a continuum of services exist as the population ages?
- Is the model administratively simple, i.e., low on paperwork and low on hassles?

Health care should be done in collaboration and in cooperation with the various stakeholders both public and private sector and it should foster competition.

- Is there provider acceptance to the approach?
- Does it create an atmosphere that fosters competition, collaboration, and cooperation especially beyond primary care?
- Has the government's role in facilitating competition been made clear?
- Does it provide a way for dealing properly with providers?
- Does it encourage a better-informed consumer?
- Do the State's educational institutes, e.g., College of Medicine, Community Colleges, and other allied health-training program have a clearly defined role in supporting the system?
- Have the appropriate linkages to employers been established?
- Does the model have adequate links to economic / workforce development?
- Are commercial carriers involved in the model?

Diagram 1: Summary of Guiding Principles and Fundamental Beliefs



Final Recommendations

The Statewide Health Care Insurance Plan Task Force formally adopted two recommendations at its last meeting in December 2001. These recommendations are described in detail below.

Recommendation 1: Adoption of Proposed Enabling Legislation

The Task Force formally voted to adopt proposed enabling legislation that establishes a more defined framework within which the State can continue its efforts to develop a seamless health care system in Arizona through the implementation of various strategies over the next two to three years. More specifically this legislation, a copy of which is included as an attachment in Section 4, sets forth the following:

- Changes the name of the Task Force to the Statewide Health Care System Task Force; adding three additional members (i.e., persons from House of Representatives, Senate and University of Arizona Health Science Center) and extending the life of the committee until December 31, 2004.

- Requires the Task Force to make recommendations to:

  - Narrow the gap between existing public and private health coverage programs (e.g., through implementation of insurance reform, consumer and employer education initiatives, private-public coverage programs, program for cooperative purchase of employee healthcare benefits by small group employers).
  - Restructure current state employee and retiree health care coverage programs (e.g., self-insurance system and expansion of pool size).
  - Enhance existing public supported programs (e.g., effective outreach programs, expansion of coverage groups).
  - Improve the rural health care infrastructure through a variety of strategies including development of a plan to more effectively coordinate current rural health care resources and programs.

- Requires the Task Force to engage in a partnership for the statewide health program with the federal Centers for Medicare and Medicaid Services.

- Requires the Task Force to submit an annual report on or before November 15 to the Governor and Legislature.

This proposed legislation will be introduced during the 2002 Legislative Session.

Recommendation 2: Support of HealthCare Group Changes

While the current economic climate in Arizona does not lend itself to the implementation of new programs, the Task Force felt that it was important to try and maintain those programs that have

proven to play an effective role in making health care coverage accessible and affordable to Arizonans. To that end the Task Force supported the continuation of the HealthCare Group program and formally adopted a series of proposed changes to the program. While HealthCare Group would continue to target the small employer group marketplace between 1 and 50 employees and political subdivisions regardless of size, the adopted proposed changes included the following:

- Change the eligibility process for HealthCare Group by gathering sufficient household income information so that only those with no other public programs available to them are enrolled in HealthCare Group and have the ability to receive the state-only subsidies associated with the program.

- Streamline the benefit options offered under the managed care delivery system into a single uniform statewide coverage option including identical covered services, copays and benefits levels. Riders or other modifications would not be offered.

- Expand the HealthCare Group Administration to assume the primary responsibility for eligibility determination, enrollment and disenrollment with the HealthCare Group health plans focusing solely on the delivery and management of the care.

- Revise the underwriting methodology in order to develop a premium structure that uses an incremental scale based on employee age and household income. The scale can be coordinated with existing income eligibility guidelines for state and federal programs and can be set so persons with higher incomes will not receive state-subsidies.

SECTION 4. ATTACHMENTS

(The following documents may either be viewed on the AHCCCS-HRSA Web site or requested through AHCCCS using the contact information on the Web site.)

This list identifies the specific handouts from each of the Task Force meetings, copies of which are contained in this section.

I. 11/30/00 Meeting

A. Representative Carruthers' memo to Task Force members on problems of health coverage in rural Arizona
B. *Comparison of Six Arizona Rural Managed Care Center Counties* by Southwest Border Rural Health Research Center
C. Handout for Southwest Border Rural Health Research Center presentation entitled *Impact of Medicare HMO Pullout in Arizona Rural Counties*

II. 1/5/01 Meeting

A. Senator Cirillo's diagram of the health care system
B. Handout for the AHCCCS Administration Proposition 204 presentation
C. Handout for William M. Mercer presentation entitled *Research and Analysis of Population, Health Care Program Utilization, Access to Providers and Cost to Provide Care through State Funded and/or Administered Programs*

III. 5/14/01 Meeting

A. May 14, 2001 memo from Jason Bezozo to Task Force on Summary of 2001 Health Care Legislation
B. Overview of Health Resources and Service Administration State Planning Grant and Timeline
C. Overview of Proposition 204 Implementation
D. Process for the Development of Guiding Principles

IV. 8/23/01 Meeting

A. Update on Implementation of New AHCCCS Programs
B. Draft of Statewide Health Care Insurance Plan Task Force Guiding Principles
C. Accessing Arizona's Health Resources and Services Administration State Planning Grant Web Site
D. Handout for William M. Mercer Presentation on Policy Issue Papers: Identification of Sub-Populations, Strategies to Improve Rural Access to Health Care and Critique of Proposed Basic Benefit Package

E. Handout for Milliman USA Presentation on Policy Issue Papers: Incentives to Increase Health Coverage, State High Risk Pools, Purchasing Pools and International Health Care Delivery Systems

V. 9/27/01 Meeting

A. AHCCCS Administration Diagrams Related to Health Care Coverage in Arizona
B. Handout for William M. Mercer Presentation on Information Update from the Policy Papers: Uninsured Population Between 45 – 64 and Cost Impact of Health Benefit Mandates
C. Handout entitled *Update from the Technical Advisory Committee*

VI. 11/14/01 Meeting

A. Handout for William M. Mercer Presentation on Three Policy Issues: Health Insurance Administration Costs, Elasticity of Demand for Health Care and Health Insurance and Self-Insuring for Health Benefits
B. Handout for Buck Consultants Presentation on Self-Insurance and State Employee Health Care Coverage
C. Draft for Statement of Legislative Intent

VII. 11/26/01 Meeting

A. Handouts for Arizona Association of Community Health Care Centers Presentation entitled *Access to Primary Care – A Community Health Center Plan for Arizona (2002-2006)* and *Arizona Association of Community Health Center Members, November 30 2001*
B. Recommendations from Arizona Association of Community Health Care Centers to the Statewide Health Care Insurance Plan Task Force
C. Handout for Southwest Border Rural Health Research Center Presentation on Assessment of Arizona Health Care Coverage

VIII. 12/11/01 Meeting

A. Handout for William M. Mercer Presentation on Follow-up Information Related to Self-Funding Programs
B. Overview of Proposed Changes to HealthCare Group
C. Handout for Southwest Border Rural Health Research Center Presentation Follow-up Information Related to Assessment of Arizona Health Care Coverage
D. Draft of Proposed 2002 Legislation